



VOICE OF THE DIABETIC

A SUPPORT AND INFORMATION NETWORK

The Diabetics Division of The National Federation of the Blind

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These eyes

by Royanne R. Hollins



Royanne R. Hollins is a blind diabetic who uses alternative techniques to remain active in mainstream society.

These eyes were crying. These eyes longed to see again. These eyes were crying. These eyes longed to see again.

These eyes were crying. These eyes felt a loss. However, now these eyes are growing stronger as I learn Braille, mobilize with a long white cane and guide dog, and use new technological advancements of voice synthesizers and scanners at work. These eyes are growing stronger. They are adapting and learning to accommodate the visual loss.

These eyes longed to see their family — their husband and two growing boys — clearly again. These eyes were longing. These eyes longed to see the smiles of friends.

These eyes longed to be the tools used in driving a car again.

These eyes have become beautiful. These eyes show a joy of life through them. These eyes are beautiful. These eyes leap for joy as I understand Braille and learn to decipher the voice synthesizer on my new computer at work. These eyes longed to be the tools of choice but have now taken a back seat in my life.

These eyes are beautiful. These eyes are hazel in color and wear mascara or colorful paint just right. These eyes are beautiful.

These eyes are thankful. These eyes are thankful for the fingers that read Braille to them. These eyes are thankful for the brain that stores knowledge and messages of orientation and mobility. These eyes are thankful for the feet that take them on the path to excitement and adventure. These eyes are thankful.

These eyes are learning. These eyes are learning that the body functions together as a whole unit, yet if part of that unit is missing or taken away, the body can learn to adapt and accommodate the part that is missing or lost. These eyes are learning day by day, step by step.

These eyes long to be healthy again. These eyes have suffered. They have suffered the ravages of long-term insulin-dependent diabetes. Through this suffering these eyes are now teaching people and helping to educate people about diabetes and its complications. These eyes have now become helpful to others.

These eyes have seen a lot

through their lifetime. With the help of the rest of their body they will continue to see many more things over the coming years.

These eyes are OK now. They don't need to see themselves to be OK. These eyes are OK now. They see through family, friends, situations and circumstances.

These eyes have been touched by God. His hands lay upon them and make them strong. His wisdom teaches them. His caring gets them through, day by day, step by step. Through the touch of God, these

eyes are beautiful, joyful and thankful. They continue to get stronger and learn from their surroundings, as well as from within.

These eyes cry no more over the loss of sight. These eyes are happy. These eyes are joyful. These eyes are thankful... these eyes are *MINE*.

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Voice of the Diabetic is a national publication of the Diabetics Division of the National Federation of the Blind. It is read by those interested in all aspects of blindness and diabetes. We show diabetics that they have options regardless of the ramifications they may have had. We have a positive philosophy and know that positive attitudes are contagious!

News items, change of address notice and other magazine correspondence should be sent to:

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Social Security, SSI, and Medicare facts for 1991

by James Gashel



Marc Maurer, President, National Federation of the Blind, leads the largest group of organized blind citizens in existence. The Federation has more than 50,000 members.

This article appeared in the January, 1991 issue of the Braille Monitor, a national magazine published by the National Federation of the Blind. If you have questions, please contact James Gashel, National Federation of the Blind, 1800 Johnson Street, Baltimore, MD 21230; telephone: (301) 659-9314.

The beginning of each year brings with it annual adjustments in Social Security programs. The changes include new tax rates, higher exempt earnings amounts, Social Security and SSI cost-of-living increases, and changes in deductible and co-insurance requirements under Medicare. Here are the new facts for 1991:

FICA (Social Security) Tax Rate: The tax rate for employees and their employers during 1990 became 7.65% and will remain at the same rate for 1991. This rate includes payments to the Old Age, Survivors, and Disability Insurance Trust Fund of 6.2% and an additional 1.45% payment to the Health Insurance Trust Fund. The maximum FICA amount to be paid by an employee during 1991 is \$5,123.30, up from \$3,855.60 during 1990. The largest amount of this increase results from a higher ceiling on taxable earnings used to support the Health Insurance Trust Fund. Self-employed persons will pay a Social Security tax of 15.3% during 1991, and their maximum Social Security contribution will be \$8,170.20. Self-employed persons who earn more than \$53,400.00 will also pay an additional amount into the Health Insurance Trust Fund.

Ceiling on Earnings Subject to Tax: The taxable earnings ceiling for Social Security purposes was \$51,300.00 for 1990. Earnings above this amount were not subject to FICA

contributions. Beginning in 1991 there is a new higher ceiling on earnings that are taxable for purposes of Medicare. The ceiling on earnings subject to tax to support the Social Security trust funds will be \$53,400.00 during 1991. The new Medicare ceiling will be \$125,000.00. Persons who earn more than \$53,400.00 will continue to make a 1.45% tax contribution to the Health Insurance Trust Fund up to the new higher ceiling of \$125,000.00.

Quarters of Coverage: Eligibility for retirement, survivors, and disability insurance benefits is based in large part on the number of quarters of coverage earned by any individual during periods of work. Anyone may earn up to four quarters of coverage during a single year. During 1990 a Social Security quarter of coverage was credited for earnings of \$520.00 in any calendar quarter. Anyone who earned \$2,080.00 for the year (regardless of when the earnings occurred during the year) was given four quarters of coverage. In 1991 a Social Security quarter of coverage will be credited for earnings of \$540.00 during a calendar quarter. Four quarters can be earned with annual earnings of \$2,160.00.

Exempt Earnings: The earnings exemption for blind people receiving Social Security Disability Insurance (SSDI) benefits is the same as the exempt amount for individuals age 65 through 69 who receive Social Security retirement benefits. The monthly exempt amount in 1990 was \$780.00 of gross earned income. During 1991 the exempt amount will be \$810.00. Technically, this exemption is referred to as an amount of monthly gross earnings which does not show "substantial gainful activity." Earnings of \$810.00 or more per month before taxes for a blind SSDI beneficiary in 1991 will show substantial gainful activity after subtracting any unearned (or subsidy) income and applying any deductions for impairment-related work expenses.

Social Security Benefit Amounts for 1991: All Social Security benefits, including retirement, survivors', disability, and dependents' benefits are increased by 5.4% beginning January, 1991. The exact dollar increase for any individual will depend upon the amount being paid.

Standard SSI Benefit Increase: Beginning January, 1991, the federal payment amounts for SSI individuals and couples are as follows: individuals, \$407.00 per month; couples, \$610.00 per month. These amounts are increased from: individuals, \$386.00 per month; couples, \$579.00 per month.

Medicare Deductibles and Co-insurance: Medicare Part A coverage provides hospital insurance to most

If you or a friend would like to remember the Diabetics Division of the National Federation of the Blind in your will, you can do so by employing the following language:

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Social Security beneficiaries. The co-insurance payment is the charge that the hospital makes to a Medicare beneficiary for any hospital stay. Medicare then pays the hospital charges above the beneficiary's co-insurance amount. The Part A co-insurance amount for hospital stays from 61 through 90 days is \$157.00 a day, up from \$148.00 a day in 1990. Each Medicare beneficiary has 60 "reserve days" for hospital stays longer than 90 days. The co-insurance amount to be paid during each reserve day is \$314.00, up from \$296.00 in 1990.

The Medicare Part B (medical insurance) deductible will increase from \$75.00 in 1990 to \$100.00 in 1991. This is not an annual deductible amount. A new benefit period can begin 60 days after discharge from a hospital or skilled nursing facility. The Medicare Part B basic monthly premium rate will increase from \$28.60 charged to each beneficiary during 1990 to \$29.90 per month during 1991.

Find key in fighting diabetes

NEW YORK (AP) — Scientists today reported identifying a target of an immune system attack that precedes diabetes, a discovery that could help in predicting and someday even preventing the disease.

The target is an enzyme in the insulin-producing cells of the pancreas, researchers said in the British journal *Nature*.

"This really is exciting stuff. ... I think clearly it will be one of the major papers in diabetes in the last several years," said Kenneth Farber, director of research at the Juvenile Diabetes Foundation International.

His organization helped fund the research.

The study dealt with insulin-dependent diabetes, the most severe form, which affects about 1 million people in this country. They must take daily insulin injections to survive.

Symptoms appear after the body's disease-fighting immune system has destroyed most of the insulin-producing beta cells of the pancreas.

Scientists do not know what triggers that onslaught. But they have found that the immune system begins attacking several specific targets long before the disease is diagnosed.



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What color is the sun?

by Lauren L. Eckery



Lauren L. Eckery tells about the perception of sight and overcoming attitudinal barriers.

This article appeared in the Fall 1989 issue of News From Blind Nebraskans, the publication of the National Federation of the Blind of Nebraska. Although this article was published some time back, it is not outdated.

The burning hot sun of midsummer is shining brightly today as I sit out here on the patio beginning to write. What *color* the sun is, is not particularly relevant to me at this moment. I know that for some blind people the color of the sun or, for that matter, what anything looks like visually, seems irrelevant. I do not take this view, however. I am highly interested in my world, including what things look like. There are those who might insist that this could not be so.

Back in 1972, when I was nearing graduation from the University of Nebraska at Lincoln, a sighted male friend and I were discussing my future. This was a friend I very much liked and trusted. However, he knew nothing about the National Federation of the Blind and its positive philosophy of blindness.

I had been approached by the Federation in 1971, had been reading the *Braille Monitor*, but had only begun to assimilate our philosophy on blindness. Therefore, neither of us understood what he was really saying when he remarked: "When you get an apartment of your own, if you have cockroaches, they won't bother you because you won't see them, so you won't even know they are there. Besides, if you don't know what they look like, then you won't know how awful they are." I thought this statement odd and rather gross, and I laughed. I was not aware at that moment that he had indeed epitomized the heartbreaking experience of many of us.

As Pearl S. Buck has written: "There were many ways of breaking a heart. Stories were full of hearts being broken by love, but what really broke a heart was taking away its

dream — whatever that dream might be."

My dream, of course, was to be a normal, first-class citizen in our society. My dream, at that particular time, might have included him in that apartment of the future. He had obviously highly respected me as a student, equal to himself, but he really did not respect me as a blind person.

It was only recently, as I began formulating this article, that I remembered his words of 17 years ago, realizing at once, with my Federation training, what he had really said. I noticed quite a number of attitudinal "cockroaches" in his remarks.

Attitudes like those exemplified in this person's remarks often bring about our being denied opportunities for normal experiences in the world. As far as visual cues are concerned, many such cues about our world are kept from us. As an example: what color something is or where something is located. On the other hand, often we are given far too many details about visual aspects of our world. An example being the clock method on the dinner plate.

Behind all of this thinking are ingrained beliefs similar to those espoused, by implication, by my university friend of 1972. Evidently he assumed that a blind person keeping an apartment by him- or herself would necessarily have cockroaches, since blind people couldn't possibly keep the place clean. (I may not be the best housekeeper, but blindness is not the reason.) If we can see, we automatically notice everything in the world there is to see and we know more about our world because we see it. If we cannot see, we know nothing about the visual qualities of the things in our world — indeed, we know very nearly nothing at all — forget about the use of other senses, and, of course, forget about our ability to reason.

Countless times in our lives we have heard such expressions as: "Out of sight, out of mind," "Seeing is believing," "What you don't know (or see) won't hurt you." These are all suggestions of lack, loss, and inferior capacity for reasoning.

How misinformed was this fine young man, even though he had known me for several years. How misinformed was I to the extent that I was unable to set him straight about blindness, resulting in discouraging him from remaining in a prominent place in my life.

On the other hand, as I began to grow in the Federation, I learned from those who were willing to teach me, and I have also learned from experience (sometimes the hard way) some of the realities of blindness — mainly attitude problems and their impact on our lives and the means for resolving such problems. I have also learned (sometimes the hard

way) that standing up strongly against such attitudinal barriers, as a unified collective body, will change these negative attitudes once and for all. Shared individual positive experiences can also help toward exterminating such cockroaches from our lives. Toward this end I relate the following experiences:

When I entered into my course of study at the University of Nebraska at Lincoln, I lived at home. Later I moved to the dorm, thank goodness! Everyday on the way to school we passed a certain building. One day I asked my mother what that particular building looked like. I was startled by her honest answer: "Laurie, we drive past that building every single day. I don't know what it looks like. I haven't really looked at it." Later, of course, she surveyed the building closely, describing it in such detail that if another blind person had asked me what this building looked like, I could have given as accurate a description of the building as my mother had given me.

This is, indeed, a lesson which many people (blind or sighted) fail to learn about sight. Sighted people do not necessarily know more about our world than blind people do. They do not have a constant edge on us simply because they can see and we cannot. Neither are blind people necessarily ignorant about their world simply because they are blind. The blind people I know who are less knowledgeable about their world tend to be those who are bitter about their blindness, refusing to concern themselves with visual factors. This lack of concern may also be noticed in blind people who have not had, or taken, the opportunity to learn alternative techniques of daily living. Or it may be simply that some folks just don't care about those things. Blindness itself does not shut us off from or out of our world.

Another example of this lesson came to me recently. Only several weeks ago my eight-year-old daughter, Lynden, asked: "Mommy, what color is the sun?" She blinks and often sneezes upon looking directly at the sun. Was it possible that she never looked long enough to notice the color of the sun? Was she testing me to see if I knew the color of the sun? What answer did she expect to get from me, the standard "yellow"?

I am totally blind since birth due to congenital glaucoma. I have no vision in the left eye. Before glaucoma took my right eye, I could see light, dark, and blobs of color. I cried the evening before the surgery, panicked a few times immediately thereafter, and that was it. I was not bitter about never seeing another sunset, because I knew that in my mind's eye I could conjure one up easily enough if I wanted to do so. Perhaps this is similar to the manner in which

Beethoven was able to write some of his best music when he could no longer hear — he had a good mind, and he used it.

I told Lynden that in the middle of the day the sun is said to be yellow, although it always looked white to me. I explained that toward sunset the color could change from a brighter yellow, becoming more and more orange, sometimes setting in a brilliant red-orange ball with other colors around it (clouds, I surmised). When this occurs, the bright fiery ball on the horizon looks as though it is resting on the ground, quite far away. Eventually it disappears. Sometimes the clouds hide the color. Often the sun does just the opposite at sunrise. Sunrises and sunsets can vary. Artists have painted them; writers have described them in words. Some people often do not notice them at all, but they are there.

"I've never seen the sun change color like that. Why does it change color? Why does it look like the sun is on the ground?" she asked, curiously. Her questions were getting beyond me. I didn't know enough about the physical properties of light, color, refraction, and distance, plus the rotation of the earth, etc., to explain it all to her. Anxiously I said: "Ask your science teacher when school starts again."

With a sigh of relief, I presumed the subject closed, only to hear: "Mommy, could you see rays coming out of the sun?" I told her I couldn't.

"Me neither," she replied. "Then why do people make pictures of the sun with rays coming out all around it?" she continued.

I thought: "Ask your art teacher when school starts again." However, being somewhat more artistic than scientific, I explained that maybe it was an artistic way to show that light and heat were coming from all directions from the yellow circle which represented the sun in the pictures. That was the end of the discussion for the time being.

I believe that, due to stereotypical thinking, Lynden was surprised by the answer she got from a totally blind person. I was equally astonished that a sighted child would bother to ask a totally blind person to describe something visual, taking the answer seriously. I believe we both learned something extremely valuable from this experience.

The knowledge gained and the joy received from this experience were made evident this past weekend as we were riding the bus home from Kansas City to Omaha. Lynden had been sleeping, and I was listening to my Talkman. Suddenly she shouted, with obvious delight, "Mommy, the sun is orange and it is on the ground just like you said." (It looked like it was on the ground.) "It is red-

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Plans to prosper

by Elaine Lewis



Elaine Lewis has experienced complications of diabetes, but her faith has not allowed her to be defeated by the disease.

From the Editor: I first contacted Elaine Lewis several years back, making her aware of our NFB Diabetics Division and the outreach work we do. Since that time she has been a member of our support network and always does whatever possible to help her fellow diabetics. Elaine is outgoing and always has a thoughtful word of encouragement for others who may be experiencing difficulties with their diabetes.

In a conversation of Thursday, February 7, 1991 Elaine said she was feeling good and getting stronger every day. She is a survivor and would want everyone to "SMILE" because it's going to be a great year.

In August 1975, a week before my freshman year of high school, I discovered that I had diabetes. My doctor admitted me to the hospital to stabilize my blood sugar and teach me both how to give insulin injections, and the importance of insulin, diet and exercise in the management and control of my diabetes. But my *only* concern was missing the first week of my freshman year of high school.

Over the next several years, I handled my diabetes pretty well, only being hospitalized two or three times. It was during this time that I became interested in medicine and decided that I would make nursing my career.

In the fall of 1979, after graduating from high school, I began attending nursing school. The next three years were a struggle, both academically and physically. I was always tired, my legs hurt so badly I could hardly walk, and my sight began to fail. Despite my health problems, I returned for my senior year of college, for I knew no other options. I was a half hour late for class the first day because my legs hurt too much to walk very fast. I had to stop quite often to rest. When I finally arrived, I could hardly read the blackboard or the small print of my textbooks.

After class, a friend drove me to her house and I phoned my parents to let them know what was happening. Mom suggested that I come home in order to get the necessary medical attention I needed in the St. Louis area. The next day I went to the nursing school administration and signed up for a leave of absence from school, planning to return for the winter semester of the 1983 school year. I returned home and found a doctor who specialized in diabetes. He put me in the hospital in order to get my diabetes under control. He decided to put me on an insulin pump. After two weeks in the hospital, I transferred to another hospital to have laser treatments on my eyes.

During the next six months, I had several laser treatments. In March 1983, I had a vitrectomy on my left eye. Despite all efforts, my vision did not improve.

During this time I also began having stomach problems. I couldn't keep food down and had severe abdominal cramps. During the next three years, I was in and out of the hospital almost every month due to stomach problems.

In February 1986, my doctor sent me to the Mayo Clinic in Rochester, Minnesota for the purpose of diagnosing my abdominal problems. The doctors determined that my stomach was paralyzed due to neuropathy. Consequently, it did not digest food normally. The only solution was to insert a feeding tube into my stomach, which they did. This is how I received my nutrition over the next four years.

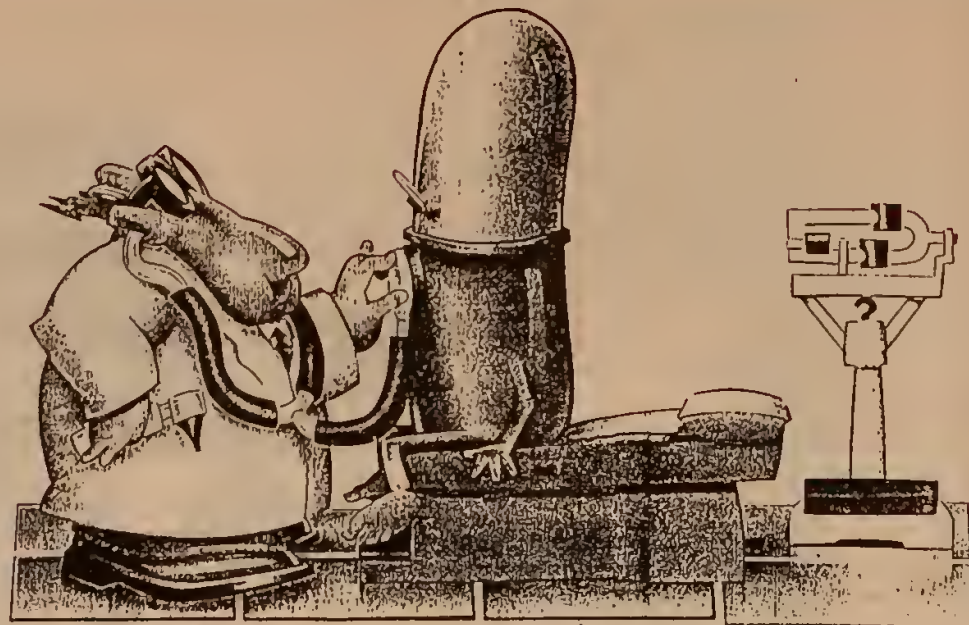
In October 1989, I began taking an experimental medicine, Cisapride, which was supposed to synthetically stimulate my stomach to digest food. At first, the medicine didn't seem to work very well. In March 1991, my doctor suggested that I try eating small amounts of food. Gradually and slowly, I began to be able to eat most foods again.

My health since that time has been pretty good. I am no longer on the insulin pump. Instead I take three injections a day of Ultra Lente and Regular insulin. I have gained both weight and strength. Although I am legally blind, I still see a little and I am very thankful for the sight I have.

There have been many times when I have been afraid and confused, not knowing which way to turn. I thank God for bringing me through all of these struggles. Without a strong faith in God, I don't think I could have managed and coped quite so well.

Through God, there is hope for a better future, for it is through Him that I have been greatly blessed. He has given me a loving, supportive family and many friends and acquaintances

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Why generic drugs are O.K.

by Joanne Silberner

Health—They are cheap and still work, despite recent publicity

Generic drugs have taken considerable heat of late, leading many people to ask themselves whether taking the drugs, which are less expensive copies of brand-name prescription medications, is such a good idea. The answer is that you do *not* have to purge your medicine cabinet.

The question arose last spring, after the Food and Drug Administration found that several generics manufacturers had faked or altered test results submitted to the FDA to get their drugs approved. Three FDA employees also admitted accepting gifts from generics makers. But most experts agree with pharmacologist Joe Graedon, author of the *People's Pharmacy* series of books: "Over all, generics still appear safe and effective, and represent an extraordinary price savings."

Last month, prompted by congressional investigations, the FDA began analyzing the 30 most prescribed generic drugs for quality, inspecting the plants of the 20 leading generics manufacturers and checking its own files to see if the paper work for the drugs' approvals is in order. Already, 27 generics have been removed from the market by the manufacturers or the FDA and production of 141 others temporarily suspended, including two unbranded versions of a popular blood-pressure drug.

But the problems uncovered so far relate to alleged fraud or paper-work irregularities. They have nothing to do with either the safety or effectiveness of any generic drug sold then or now. People who would rather not use recalled drugs can call their pharmacist, doctor or one of the local FDA field offices, located in about two dozen major cities, to see if any drugs they might be taking have been pulled off the market. Simply stopping a prescription drug, however, poses a genuine risk for a sick person.

Who makes what. The line between generics and brand names is hardly as sharp as the recent publicity suggests. In the 1970s, the bigger pharmaceutical manufacturers put up a solid front against generic drugs. They argued that the large profits from brand-name products were needed to support costly research on new drugs and that generics manufacturers operating on low profit margins would struggle to meet high standards of safety and effectiveness. Nowadays, however, some of the established houses, among them Warner-Lambert, Lederle and Squibb, produce generic versions of their rivals' brand-name drugs. Industry experts estimate that half or more of all generic drugs, in fact, are made by brand-name companies. And some brand-name drugs are manufactured under contract by generics companies.

No medication, branded or generic, is risk-free. For that reason, the FDA routinely checks drugs on the market for the correct active ingredients in the right amounts, accompanied by proper labeling. The agency keeps no official tally, but a spokesperson says both branded and generic drugs have come in for their share of recalls. Says Dr. Sidney Wolfe of the Washington, D.C.-based Public Citizen Health Research Group, a sharp critic of both the FDA and the pharmaceuticals industry: "The major drug disasters in this country all involve brand-name drugs that have come on the market recently." He points to Oralflex, an arthritis drug pulled off the market within three months of its introduction after being linked to 72 deaths in the U.S. and Britain.

Still, the current troubles have renewed the old debate about whether a generic drug that satisfies FDA

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FDS-264

Legislative agenda for the blind of America



James Gashel, Director of Governmental Affairs, National Federation of the Blind, works diligently with Congress to improve the lives of the blind.

(Editor's Note: The following release from our National Federation of the Blind addressed to members of Congress is available separately, as are the Fact Sheets mentioned below (but not reprinted here). For these or further information, contact: James Gashel, Director of Governmental Affairs, National Federation of the Blind, 1800 Johnson Street, Baltimore, MD 21230; telephone: [301] 659-9314.)

From: Members of the National Federation of the Blind
To: Members of the 102nd Congress
Re: The Blind — Legislative Priorities for the 102nd Congress, First Session

Public policies and laws affecting blind people have a profound impact throughout our society. Most people know someone who is blind. It may be a friend, a family member, or a co-worker on the job. One-half million people in this country are blind, and fifty thousand Americans become blind each year. By themselves these numbers may not seem large, but the social and economic consequences of blindness directly touch the lives of millions. Less directly, blindness affects us all.

Blind persons as a group share a unique struggle. If a blind person has proper training and opportunity, the physical loss of eyesight itself can be reduced to the level of a mere nuisance. Misconceptions about blindness, coupled with lack of good training and limited opportunities, are the real problems. Although most sighted people have had some contact with blindness, it is still largely misunderstood and continues to be more a problem of public attitudes and perceptions than physical disability.

Public policies and laws that result from misconceptions about blindness or lack of information are often more limiting to the blind than loss of eyesight itself. This is why we have formed the National Federation of the

Blind. The Federation is a private-sector resource of knowledge, encouragement, and support for the blind and for anyone (blind or not) who wants to join in the effort we are making to win understanding and opportunity.

Blind people are well-organized at the community and grass-roots levels throughout the United States. Our policy positions are developed and determined by vote of the blind themselves. This is why the Federation is known by lawmakers and the public as the "voice of the nation's blind." Our priorities for the first session of the 102nd Congress express our assessment of the current issues requiring action by Congress on behalf of blind persons of all ages.

(1) *Congress should amend the Rehabilitation Act of 1973 to establish the client's right of choice in selecting agencies to provide rehabilitation services.* Blind persons eligible for rehabilitation have the right to receive services, but personnel of designated state agencies are empowered to make most of the planning decisions and arrangements for service. The client's views must be considered if expressed, but state personnel make all of the final decisions. Funds to support rehabilitation can be and are withheld if the client does not cooperate. Cooperation means receiving services from programs prescribed by state personnel.

The proposed legislation will achieve better matching of clients with compatible programs by empowering them to take charge of selecting sources for all services. As persons with disabilities begin to experience and exercise newly won legal rights, there will be a growing demand and need for services chosen by clients, not by agencies. Students who receive Federal aid to attend post-secondary institutions choose their own schools and select their courses of study. Elderly and disabled recipients of health services paid for by Medicare choose the doctors they will see, and the bills are paid by Medicare. Not so in rehabilitation. Congress should change this policy. For more details and a description of the need for this legislation, see the fact sheet entitled "EMPOWERMENT IN REHABILITATION: EXPANDING CHOICES FOR BLIND ADULTS."

(2) *Congress should insure that politics in the form of accreditation does not threaten programs serving the blind.* Federal funds received by all rehabilitation agencies could be jeopardized by a proposal of the National Accreditation Council for Agencies Serving the Blind and Visually Handicapped (NAC). NAC wants to convince Congress to require accreditation as a condition of eligibility for any agency to receive Federal funds. According to NAC this plan would promote accountability and program quality.

Here is the real story. NAC is struggling to survive. After 25 years of trying, NAC's standards and procedures have not been accepted by agencies serving the blind. Less than 100 (not even 20 percent) of the blind service agencies have chosen to become NAC members. The drop-out rate among NAC's affiliates is 21 percent and climbing. NAC's directors have now concluded that Congress could solve their problems by mandating accreditation, but the plan lacks widespread support. Strong opposition is expected from the Bush administration and from most groups potentially affected by such a requirement. Federal funds, used to establish and support NAC in its early years, were withdrawn in 1975 in the face of low agency acceptance of the NAC standards and consumer concerns raised about the NAC accreditation process. These conditions still exist. For more details and suggested actions by Congress, see the fact sheet entitled "POLITICS IN THE FORM OF ACCREDITATION: A THREAT TO PROGRAMS AND SERVICES FOR THE BLIND."

(3) *Congress should safeguard business opportunities for blind vendors on Federal highways.* In 1982 Congress enacted legislation to promote economic opportunities for blind persons in the conduct of sales through vending machines at highway safety and rest areas. The provision authorizing this program is commonly known as the "Kennelly Amendment." Congresswoman Barbara Kennelly sponsored the amendment at the request of the National Federation of the Blind and worked closely with the Federation in steering this measure through Congress.

The Kennelly Amendment could be threatened by proposals to commercialize services provided at highway rest-stops. Under current law, services (other than sales through vending machines) are prohibited at these sites. However, the American Association of Highway and Transportation Officials (AASHTO) is seeking legislation to authorize roadside services to be provided through agreements with commercial developers. As many as 1,400 sites are planned for initial development with hundreds more to follow. Plans include using commercial firms to provide rest area services, motorist information services, food services, and fuel. Provision of services by blind persons is not contemplated by AASHTO's plan, but the popularity of Kennelly Amendment vending machine sites is acknowledged. For more details and suggested actions by Congress, see the fact sheet entitled "BUSINESS PRIORITY FOR BLIND VENDORS: PROTECTION NEEDED IN SURFACE TRANSPORTATION AMENDMENTS."

(4) *Congress should amend Section 8(a) of the Small Business Act to include individuals with disabilities as*

a defined minority group for purposes of eligibility in the Minority Small Business and Capital Ownership Development Program. The Section 8(a) program is designed to foster business ownership by individuals who are both socially and economically disadvantaged, and to promote the competitive viability of such firms. To achieve these goals, Section 8(a) authorizes the Small Business Administration (SBA) to enter into all types of contracts with government departments and agencies for supply, service, construction, and research and development. Small business concerns owned and controlled by socially and economically disadvantaged persons can be eligible to receive subcontracts to fulfill SBA's procurement obligations. Technical assistance is also made available to minority small business concerns.

This proposal is simply the recognition of disability as a condition of defined minority status for participation in SBA's targeted efforts to provide economic and technical assistance to members of minority groups. The social and economic disadvantages which accompany disabilities are well-known and should be beyond dispute. Blind persons have traditionally had few opportunities to become employed and even fewer opportunities to establish and maintain their own businesses. Yet, SBA has not recognized the blind (or individuals with disabilities in general) as being socially and economically disadvantaged. The problem for SBA has been to define disability and the extent of the class of individuals included. Another problem has been SBA's lack of legal authority to incorporate such a definition in the absence of a clear legislative mandate. The Americans with Disabilities Act (Pub. L. 101-336) now provides the basis for a legislative mandate as well as an appropriate legal definition. For more details and an explanation of the need for this legislation, see the fact sheet entitled "MINORITY STATUS AND RIGHTS: A PROPOSAL FOR BUSINESS OPPORTUNITIES AND JOBS."

Blind people are asking for your help in securing positive action by Congress in the areas outlined here. Legislative proposals will be offered to achieve each of our specific objectives. Many priorities confront this session of Congress, but the needs of the nation's blind must not be overlooked.

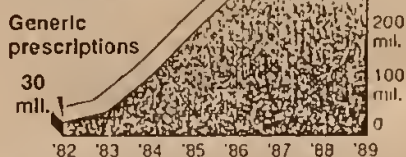
We of the National Federation of the Blind stand ready to assist our representatives and senators to understand our needs and to take meaningful action to address them. In partnership with the National Federation of the Blind, each member of Congress can help build better lives for the blind both today and in the years ahead.

Why generic drugs are O.K. (Continued from page 6)

standards is as good as the original, brand-name version. To gain FDA approval, a brand-name drug has to prove itself on 400 to 800 or more sick people, a process that usually costs tens of millions of dollars. Approval for a generic, on the other hand, only requires data showing that the drug contains the same active ingredients and is absorbed into the bloodstream of 18 to 24 healthy young people in a similar fashion to the brand-name drug (see box).

Cheap alternatives

While total prescriptions only grew from 1.47 billion in 1982 to 1.51 billion in 1989, generics' share climbed from 2 percent in 1982 to 33 percent this year.



Note: Figures for 1982-84 and 1989 are estimates. USN&WR — Basic data: HKS & Company, Warren, NJ

The issue has become a flash point for the American Academy of Family Physicians (AAFP). Last month, the AAFP's board of directors warned the group's 60,000-plus doctors of "serious concerns" over generics. In a draft report, the board said that healthy young men might absorb and break down drugs differently than sick people do, so that an ill, older woman might run into trouble. The AAFP attacked the FDA's 20 percent rule, which allows the amount of generic drug in the blood tests to vary up or down by 20 percent from the blood level of a name brand. The AAFP warned that suddenly switching from one product to another, whether from name brand to generic, from generic to generic or from generic to name brand could be dangerous. Finally, the group suggested that doctors should think twice before prescribing generics to elderly women and people with certain diseases, including asthma, depression, congestive heart failure, diabetes and heart problems, or those taking antipsychotics or diuretics.

No custom tailoring. The AAFP's objections are mostly red herrings. The 20 percent rule notwithstanding, a 1988 FDA task force found that, in practice, blood levels of generics fall within an average of 3.5 percent of their brand-name brothers. Clinical studies have shown that for most drugs a dosage that is off by 50 or even 100 percent does not matter. Few drugs are precisely tailored to the patient, anyway. A 125-pound woman usually gets the same dose as a 250-pound man, with no ill effect even though the concentration of the drug in her system is double that in his. Several drug experts estimate that the potency of many brand-name drugs can vary by 10 percent from one manufacturing lot to the

next, a variance that doesn't worry the FDA. In fact, it permits brand-name firms to change their formulations by the same 20 percent they allow the generics.

Other medical groups, moreover, are more sanguine about generics than the AAFP. The American Medical Association and the American Academy of Pediatrics advise their members to consider cost as well as safety and effectiveness when prescribing. Most hospitals use generics to save money, and many health-insurance plans that cover drugs encourage the use of generics when available.

Fueled by dire anecdotes, the debate periodically crops up in doctors' lounges and in the medical literature. A 1987 report in the *Journal of the American Medical Association* described repeated seizures in an epileptic girl who was switched from a branded to a generic version of primidone. But it turned out that when she was switched back to the brand name the seizures continued, so they may have reflected a worsening of her disease rather than a drug problem. Yet some doctors and pharmacists are suspicious enough about such switching to suggest that people with certain hard-to-control diseases such as epilepsy and heart failure remain on whatever it is they are taking. To prove that switching is bad requires a study of a group of people with the same disease, showing that some of those who switched to a different drug had problems while those who remained on a single product did well. Such a study has not been done; in its absence, switching remains a theoretical problem to be avoided by the supercautious.

As it happens, many people are switched unknowingly when they go to a different pharmacy or when their pharmacy switches generic suppliers. You should be able to tell, because by law the new and old drugs will differ in some way. The difference can be as obvious as a change in the color of a capsule or as subtle as a new manufacturing number stamped on it. You can always ask your doctor or pharmacist. Arthur Kibbe, director of scientific affairs at the American Pharmaceutical Association, urges a talk with your pharmacist *any* time you get a refill. "The pharmacist should ask you how you are doing, and whether you've changed your diet or gained weight," says Kibbe. "These things can affect how well any drug is working." The pharmacist may suggest checking with your doctor.

Change stores, not drugs. While a switch between manufacturers should not hurt you, a switch of pharmacies may save you money. A survey of pharmacies across the country released last month by the American Association of Retired Persons showed that generics at some pharmacies can cost as much as name

brands at other pharmacies. In one town, the association found, one drugstore sold 100 pills of generic hydrochlorothiazide, a diuretic, for \$2.75, while another charged \$13.90. And while one store offered 100 pills of generic propranolol, a blood-pressure and angina drug, for \$4.95, another charged \$28.30. Over all, at the 1,050 pharmacies surveyed, generics cost about half as much as brand names.

made it. Some elderly people try to stretch their health-care dollars by cutting the dosage of an expensive drug in half.

"It would be really a tragedy if older people on fixed incomes felt their confidence shaken to the point of giving up on generic drugs," says pharmacologist Graedon.

In short, there is little to fear from generics. "These drugs haven't suddenly stopped working," says Dr.

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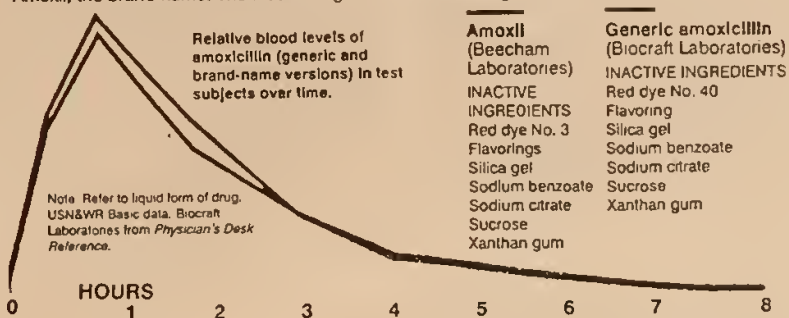
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What's the difference?

A common fear is that generic prescription drugs are not equal in quality to brand-name varieties. That is a myth. As shown below, a version of the most-prescribed generic, amoxicillin, enters the blood of test subjects in a pattern that closely matches that of Amoxil, the brand name. The inactive ingredients in both drugs also differ little.



The controversy over generics obscures a far grimmer reality. Many patients—about half, by some estimates—do not take prescription drugs as directed. This can render a drug far less effective than any difference between brand name and generic might produce. Downing the antibiotic tetracycline with a swig of milk, for instance, wipes out the drug's effectiveness no matter who

Carl Peck, who directs the FDA's generic-drug program. Experience indicates that in the vast majority of cases the relationship between brand names and generics is close enough where it really counts: In your body.

(Note: This article appeared in the September 18, 1989 issue of *U.S. News and World Report*, Copyright 1989. Reprinted with permission.)

On keeping a promise

by Charlie Mitchell



Charlie Mitchell was an Insulin-dependent diabetic who has had a kidney and pancreas transplant.

From the Editor: Charlie Mitchell is the Diabetics Division representative for the NFB of Oregon. His story is factual, and provides details of his life with diabetes.

He had kidney and pancreas transplants at the Oregon Health Sciences University in Portland. His kidney transplantation took place about six years ago. Two and a half years later, he underwent pancreas transplantation. Today, both organs are working well.

Charlie experienced much illness prior to and immediately after his transplants. But now he feels great, and is once again active and enjoying life. He is majoring in computer science at the University of Oregon, Eugene, Oregon.

"Come on, Coco, take me to the reception desk," Charlie said as he and his dog guide stepped off the elevator.

"Good dog!" Charlie proclaimed as he bent over in front of the tall reception desk to pet Coco on the head.

"I beg your pardon," the startled receptionist said as she jumped up from behind the computer where she had been working.

"Ah...please forgive me. I was talking to my dog," Charlie said as he stood up in front of the counter giving her a big grin.

"I see," replied the receptionist, staring at the grin on his face.

"Is there something that I can help you with?" she asked sternly, obviously not amused by the conversation.

"Yes, I am here for my appointment in the pancreas transplant clinic," Charlie said, still grinning.

"This is the renal transplant clinic, we don't have pancreas transplants at this hospital," the receptionist firmly stated.

"Well, perhaps you should tell this to my new pancreas," he said amusingly.

"Hold on sir, I'll call the renal transplant clinic and ask them about this," the receptionist said as she picked up the phone and started pressing numbers.

Charlie turned his head, stopping to stare in the direction of the dull light that was coming across the office. In the trance of the light, he floated mentally back some 25 years to when he first knew he was diabetic. His mother was leading him by the hand to the hospital where he was to be treated for diabetes.

"I'll take the pills, but I sure ain't going to take those shots!" Charlie protested.

"Yes, you are and you are going to have to learn to do it yourself, because I just can't do it," his mother argued.

... And then there was Mr. Chapman, a diabetic in the hospital who always walked around with a cigar in his mouth. "One day, Charlie, there will be a cure and you won't have to take those shots any more," Mr. Chapman would say confidently.

"Well, when they do I'm going to be the first in line for the cure," Charlie would say with determination.

Charlie was only ten years old when he became diabetic, but he never forgot what Mr. Chapman had said to him. He also never forgot the promise he made to himself about being the first one to be cured of diabetes. Charlie worked his way through school, eventually becoming a mechanical designer. He was doing well at this point in his life, and it looked as if he had a good future ahead of him. Then suddenly he was fired from a job for drawing some pieces of pipe backwards. He had developed complications from his diabetes after two decades of being a diabetic. The doctors told him that he was losing his eyesight due to diabetic retinopathy, and that his kidneys were failing. Two weeks after finishing intensive laser treatments for his eyes, Charlie was put on a dialysis machine because his kidneys had failed. His friends were predicting he would not live to see another Christmas.

"I'll find my own ride to my funeral, and if I don't make it there on time, you go ahead without me," Charlie would say to them.

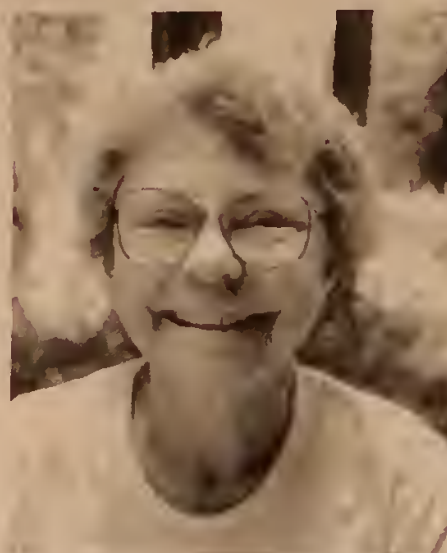
He eventually received a kidney transplant. It was then that a doctor told him the hospital would soon be starting pancreas transplantation.

"Finally! A cure for diabetes," Charlie thought. "I wonder if I could get one, and I might even be the first one," he said to himself, remembering his childhood promise.

"Sir," the receptionist said as she handed him some papers. "Now you take these papers, and you go around the reception desk, through

(Continued on page 14)

My working years with diabetes



Dolores Olson has had Insulin-dependent diabetes for 58 years, yet has had few ramifications.

During my 58 years living with diabetes I have never once experienced any type of discrimination. Forty of those years I have been in the employment arena. I was 12 years old when diagnosed and after high school attended college, where I worked part-time on campus at various student jobs. As a major in public school music and English, I taught those subjects for two years before marriage. My superiors knew of my diabetes, but raised no questions about it when told it was well-controlled. After marriage it was my preference to change from teaching to secretarial work and for the next 36 years (with one year absence when our daughter was born in 1948), I enjoyed four different secretarial jobs. Again, diabetes was never a problem.

My only working days missed due to diabetes were those at the time of laser therapy for diabetic retinopathy,

my first complication 45 years after onset of diabetes. It was my good fortune to have developed retinopathy after laser treatments proved to be so beneficial. Now after two cataract surgeries, my vision is again excellent. My retinopathist checks annually for any recurrence of hemorrhaging.

It was also my good fortune to have had access to company insurance policies, where diabetics were not excluded from coverage. After retiring in 1979, I simply converted my company policy to an individual policy, again with no restrictions.

There are always frustrating moments with diabetes and perfect control is just not possible — but if you do the best you can every day, you will find you can undertake almost any type of work you choose to do. Just remember that constant vigilance with your diet-exercise-insulin regime should be at the top of your list of priorities. In the long run it will greatly reduce your chances of developing serious complications. I have always tried to be careful and feel sure I have been rewarded for doing so. It has also been my good fortune to have a very supportive husband for 47 years. One of the greatest assets for any diabetic is complete family support.

Robert Louis Stevenson, who had tuberculosis, is reported to have said, "Life is not a matter of holding good cards, but of playing a poor hand well." I have read to many inspirational stories in the *Voice of the Diabetic* about members of our Diabetics Division who have endured serious complications and continue to play "their poor hand well" by maintaining an essential positive attitude. I salute every one of them!

Insulin 'guinea pig' lives 68 years with diabetes

PEKIN, Ill. (AP) — In 1922, Urvan Ubben's parents had his "funeral picture" taken, certain he'd be the next family member to die of diabetes.

Today, the 77-year-old laughs at the childhood photo and how he cheated death by being one of the first people to test insulin. Experts say he may be the world's oldest surviving diabetic.

"I was one of the guinea pigs when Eli Lilly was trying to mass-produce insulin in Indianapolis back in 1922," Ubben said. "In those days, they figured that if you had diabetes, you didn't have a chance. And my parents were highly skeptical of insulin."

"So when I came back from the experimental treatments in Indianapolis, my parents still thought I was

going to die and they wanted a picture of me. So they had my picture taken.

"Years later, I was looking at my mother's old pictures with an aunt. When we came across that photo, she said 'Urv, there's your funeral picture.' We just laughed about it."

Diabetes, a disease caused by excess sugar in the bloodstream, was no laughing matter when Ubben developed it in 1922.

Earlier that year, Ubben's sister Theola died after slipping into a diabetic coma. Ubben already had lost an aunt, an uncle and his great-grandfather to the disease.

"It was quite scary for my parents and they were pretty discouraged," Ubben said. "Insulin had just been

(Continued on page 13)

The Diagnosis: diabetes; the patient: your very young child Surviving a family challenge

No parent expects to raise their child without encountering some childhood diseases along the way. Measles, chicken pox, the flu, they all take their place in the cavalcade of a child's early life along with crawling, toilet training, or the first day of school.

However, few parents will ever include the day their child is diagnosed as having diabetes or the first time they have to give an insulin shot among the mental snapshots of their child's first few years. If it happens, the diagnosis of diabetes creates a whole series of physical and emotional challenges for a family. And those challenges are magnified for parents if the child is still a toddler who is not capable of understanding the disease and treatment nor of taking on even a small part of the responsibility for his or her own diabetes care.

"Unlike many of the chronic physical diseases that sometimes strike children," says Barbara Anderson, Ph.D., of Joslin's Mental Health Unit, "diabetes is different in that you don't hand your child over to a doctor to manage the child's care and treatment. With diabetes, the child is handed back to you and this can be a terrifying responsibility."

A small child with diabetes is faced with a number of very real potential problems if his or her diabetes is mismanaged, says Joseph I. Wolfsoord, M.D., chief of pediatrics at Joslin. "The beta cells that produce insulin are destroyed much more aggressively than in adolescents or adults so a distinct 'honeymoon' phase is usually not seen when diabetes develops in this age group.

"Most young children," he says, "require two injections of insulin each day to achieve satisfactory blood sugar control: one before breakfast and one before supper or at bedtime. Likewise, because they cannot recognize or interpret their symptoms or articulate their needs, more frequent blood glucose monitoring is required."

For their part, Wolfsoord notes, parents are often fearful of their child suffering severe hypoglycemia, which can lead to convulsions and unconsciousness, especially during the night when the rest of the family is asleep. And over the long term, if diabetes is not well-controlled and blood sugars are allowed to run too high, growth and weight gain might be affected for the worse.

The younger the child is and the less able he or she is to understand this disease and its complex treatment the greater the burden on the parents, says Anderson. The difficulties of having a child with diabetes range from the very basic but vital problem of getting a two-year-old to

eat his or her dinner to the more complex issues surrounding family dynamics.

Getting over it. The first obstacle faced by many parents is the shock of realizing that their child now has a chronic illness.

"At first," says Helen Kraus of Belmont, MA, single mother of then four-year-old Rachel, "I was devastated. One minute I had this perfectly healthy little girl, the next minute the doctor was telling me that she had to go to the Joslin Diabetes Center immediately."

Kraus is one of the hundreds of parents who have brought their small children into Joslin during the past several years for diabetes treatment.

"I literally did not know what to do," she says. "I didn't know the first thing about diabetes. I couldn't even tell you what it was. As time went on and I learned more about what it required to manage a child with diabetes, it was so burdensome. All this rigmarole. I would ask myself, 'Is this me? Is this my daughter?'"

"The diagnosis of diabetes has had a tremendous effect on almost every aspect of our lives," says Kay Tustison of Lexington, MA, whose seven-year-old daughter Anna was diagnosed four years ago. "We have lost a lot of flexibility and spontaneity; we wonder whether we would have moved to another area or had another child if diabetes had not become a part of our lives. In a way we have been forced into other directions to accommodate this disease."

To help parents like Helen Kraus and Kay Tustison cope with the many issues that arise following a child's diagnosis, Joslin's pediatric service runs a series of eight- to ten-week support and education groups for parents of children in a variety of age ranges. In them, Dr. Anderson works with parents who are concerned about the physical, psychological and social issues affecting not only their child with diabetes but their whole family, and who are looking for support and practical solutions. Simultaneously, Anne Vernon, R.N., C.D.E., Joslin's pediatric diabetes teaching nurse, leads an education and support group for the children of those parents.

"Diabetes puts a tremendous amount of pressure on parents, especially when the child is too young to talk about what they need or how they feel," says Anderson. "Imagine that your child might develop low blood sugar at any time and not be able to tell you what was happening. And remember that this is not a one-time stressful event, this is ongoing; these parents are dealing with these concerns on a daily basis for years."

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Getting the children to eat. For parents of toddlers, whose verbal skills are only just beginning to develop, the biggest problem is communication. And many communications issues, as the toddler tries to gain greater control of his or her own surroundings, can revolve around food. "I have seen parents so frustrated," says Anderson, "that they have found themselves on the verge of striking their child. But when eating dinner is a matter of life and death, and the kid won't eat, you can see why they might be feeling frustrated. For many parents getting the kids to eat is much worse than the shots or blood tests."

When this is the case there are several steps a parent can take to help alleviate the situation. "The most important thing to remember is that it's important not to make eating a battle. When that happens the kids will often refuse to eat at all."

Instead Anderson recommends that parents begin helping toddlers gain more control over eating by pre-cutting food into tiny, bite-size pieces so that the child can eat using his or her hands. Parents who ask their child if they can eat food from the child's plate will increase the appeal of the food. Young children will frequently eat when the pressure to eat is removed and parent can leave food out so that the children have plenty of chances to eat if they need to. Also make mealtime an enjoyable

social time by doing things like reading a story while the child eats.

The family diet. Food can become an issue for the rest of the family too. If one child can't eat sweets, is it fair to the other kids or even parents to have to deprive themselves? It's important, says Anderson, that the family's diet be adjusted so that the child with diabetes has a diet that is more or less like everyone else's for several reasons.

"First of all," she notes "many parents will say that they are actually eating better as a result of their child having diabetes. Of course, attitudes about diet have changed in the past couple of years. In our culture, today's concept of a healthy diet is now very close to the type of well-balanced diet that would be recommended for children with diabetes so there's one less hurdle, less resistance than there used to be.

"Sometimes though, the other siblings may want an ice cream cone or something like that and there's no reason to deny them. It's definitely best if it's done at a time when the child with diabetes is not present. If that's not possible then try to have an alternative treat — not necessarily food — for the child with diabetes.

"In general," she continues, "it's not fair for parents to have expectations of the child, especially about diet, if they, themselves, cannot

(Continued on page 13)

Ask Dr. James

by Ronald James, M.D.



Ronald James, M.D., long-term insulin-dependent diabetic, directs Midwest Diabetes Treatment Center, Columbia, Mo. Dr. James is also Medical Director of the Missouri Diabetic Children's Camp, Inc.

(Note: If you have any questions for Dr. James, please send them to the editor. The only questions Dr. James will be able to answer are the ones used in his column.)

I have heard that glucose tolerance tests are given for different amounts of time. Is a two-hour GT test as accurate as a longer five- or six-hour test? Why are both blood and urine taken for this test? Is the test stopped if weakness, headache, or other symptoms common to low blood sugar occur?

Yes, a two-hour glucose tolerance test is as accurate as the longer five- or six-hour test. In fact the Diabetes Data Group of the National Institutes of Health has set up standards for doing diabetes tests that will hopefully be used internationally. They recommend the two-hour glucose tolerance test. Apparently no further information is gained by obtaining additional blood glucose levels. The urine tests serve no useful purpose in diagnosing diabetes while doing a glucose tolerance test. How-

ever, urine tests done simultaneously with the blood glucoses may give some measure of the renal threshold, that is the blood glucose level at which one spills glucose into the urine.

After I get the final result from a blood glucose test, what is meant by milligrams per deciliter (mg/dl)?

The word *deciliter* refers to a volume of 100 milliliters or 100 cc's, which is slightly greater than three fluid ounces. The word *milligrams* refers to the amount of glucose that is in that amount of blood. One milligram is a very small amount of glucose. For example, one teaspoonful of sugar contains about 4,000 milligrams of sugar. Thus, milligrams per deciliter refers to the number of milligrams of glucose in slightly over three ounces of blood. Normal blood glucose is in the general range of 70-110 mg/dl. To give you some idea of how much glucose this is, a normal value of 100 mg/dl represents a concentration of about 1/10th of 1% glucose in the blood.

I have been a Type I diabetic for 25 years. My doctor claims my pancreas still produces some insulin. Do Type I diabetics produce insulin?

In general it is felt that Type I diabetics produce little or no insulin. However, in the first few weeks, months or even years after the onset of Type I diabetes, some go into remission or what is referred to as the "honeymoon period", during which time their pancreas recovers to some extent and produces some insulin. Thus, some individuals with Type I diabetes, particularly early in their course, may actually produce some insulin. If you are interested in confirming your doctor's feeling that you produce some insulin, you can obtain a test called the C-peptide. This will give you some idea of how much insulin you are actually producing regardless of how long you may have had diabetes.

wrapped it all up in the rags of my life and laid it at the Cross. Something beautiful, something good, all my confusion He understood. All I had to offer Him was my brokenness and strife. But He made something beautiful of my life."

God really has made my life beautiful. I hope that my story will be a source of encouragement and testimony to others.

Diabetic retinopathy ... current understanding

by Brian C. Lerner, M.D. and Robert P. Murphy, M.D.
The Wilmer Institute, Johns Hopkins Medical Institutions

Diabetes is a metabolic disorder caused by a lack of insulin or an inability to use insulin properly. By mechanisms not well-understood, damage occurs to small blood vessels, especially those supplying the eyes and kidneys. The discovery and wide-spread availability of insulin for diabetics, as well as improved medical care have greatly enhanced the longevity of diabetics. With increased lifespan, diabetics are more likely to develop eye complications, the most common of which is diabetic retinopathy.

To better understand diabetic retinopathy a brief anatomical view of the eye is presented (Figure 1). Light enters the eye through the cornea. Light rays pass through the lens and vitreous cavity and are focused onto the macula of the retina, just as the lens of a camera focuses light onto the film of the camera. The retina transforms this focused image into electrical signals. These signals pass through nerves which begin in the retina and extend through the optic nerve to reach the brain. This complex process requires energy which is derived from the metabolism of nutrients provided by retinal blood vessels. Diabetic retinopathy involves abnormalities of the small blood vessels that supply the retina. With damage to these blood vessels, oxygen and other vital nutrients are no longer adequately supplied.

Diabetic retinopathy exists as a spectrum of disease from very early "background" changes to advanced "proliferative" changes. In background retinopathy, damage to the retina is caused by abnormalities in the small blood vessels within the retina. In "proliferative" retinopathy, damage is caused by abnormal new blood vessel growth out of the retina.

For many diabetic patients, retinopathy does not progress beyond the background stage. However, a substantial number of patients progress to more advanced stages, known as proliferative retinopathy. In contrast to background retinopathy, the changes in proliferative retinopathy are no longer contained within the retina. In proliferative retinopathy, abnormal new blood vessels sprout from blood vessels on the optic nerve or in the retina and grow between the surface of the retina and the vitreous gel, the clear gel filling the center of the eye (Figure 2). These new blood vessels are fragile and may rupture and bleed into the vitreous gel. The blood interferes with the passage of light to the retina, and thereby interferes with the ability to see. Scar tissue frequently develops with the development of new blood vessels. This scar tissue can contract and pull on the retina. Retinal detachment can result from this pulling force, leading to

severe visual loss.

Fortunately appropriate laser treatment in most patients causes the new blood vessels to disappear or regress and strongly reduces the risk of severe visual loss. Periodic examination is essential to monitor the progress of the retinopathy, allowing detection of this severe condition. Laser intervention can then be offered at the appropriate time.

Despite the placement of this type of laser treatment, a small group of patients still develop bleeding or scar tissue in the eye. Today retinal surgeons are able to remove this blood and scar tissue from within the center of the eye by a surgical procedure known as vitrectomy. Patients after such surgery can often see well enough to get around on their own. Although vision is rarely as good as prior to bleeding into the center of the eye, vitrectomy has become an important sight-saving procedure for patients who either fail to respond to laser treatment or who develop bleeding before the diagnosis of diabetic retinopathy has been made.

Unfortunately there are usually few, if any, symptoms of progressing diabetic retinopathy even at the stage of new blood vessel growth. One can maintain excellent, 20/20 or better, vision up to the very moment bleeding into the eye occurs from fragile new blood vessels. Since such disease progression occurs without symptoms in many patients, the most important way to monitor one's risk for visual loss is by ocular examinations by a doctor trained to diagnose retinal disease. It may then be determined when medical or surgical treatment is needed so the risk of visual impairment can be reduced to the lowest possible level.

All diabetics should have a detailed eye examination as soon as the diagnosis of diabetes is confirmed. If no macular edema is present, examinations may occur every six to twelve months. Patients who have background diabetic retinopathy with macular edema are seen every four months and treated if necessary as discussed previously. At the time of examination, the doctor looks for changes known as "preproliferative retinopathy" which consists of abnormalities in the retinal veins, closure of small blood vessels and other abnormalities of the small blood vessels within the retina.

If any of the changes of preproliferative retinopathy are evident, abnormal new blood vessel growth is more likely to occur and follow-up examinations are increased to every three or four months. Proliferative retinopathy can develop rapidly from preproliferative retinopathy. If proliferative disease is present, close follow-up is mandatory so that progress to "high

Plans to prosper (Continued from page 3)

who have deeply touched my life and have been a great source of encouragement and strength.

The Gaythers wrote a song which completely expresses my thoughts: "It ever there were dreams that were lofty and noble, they were my dreams at the start. And the hopes for life's best were the hopes that I harbored deep in my heart. But my dreams turned to ashes, my castles all crumbled, my fortune turned to loss. So I

risk" retinopathy is rapidly detected. To decrease the risk of severe visual loss panretinal laser intervention is recommended if "high risk" proliferative retinopathy develops.

The ability to treat various stages of diabetic retinopathy has markedly decreased the chance of losing vision for each diabetic. This is only true if each diabetic is examined at appropriate intervals, allowing intervention to be offered when warranted.

Much of the visual loss from diabe-

tes is truly preventable. Close collaboration among the diabetic, the diabetologist, the ophthalmologist and other specialists providing care to the diabetic with prompt diagnosis and treatment can help eliminate much of the visual loss from diabetes.

(Note: This article appeared in *Progress and Prevention*, published by the Maryland Society for the Prevention of Blindness. Reprinted with permission.)

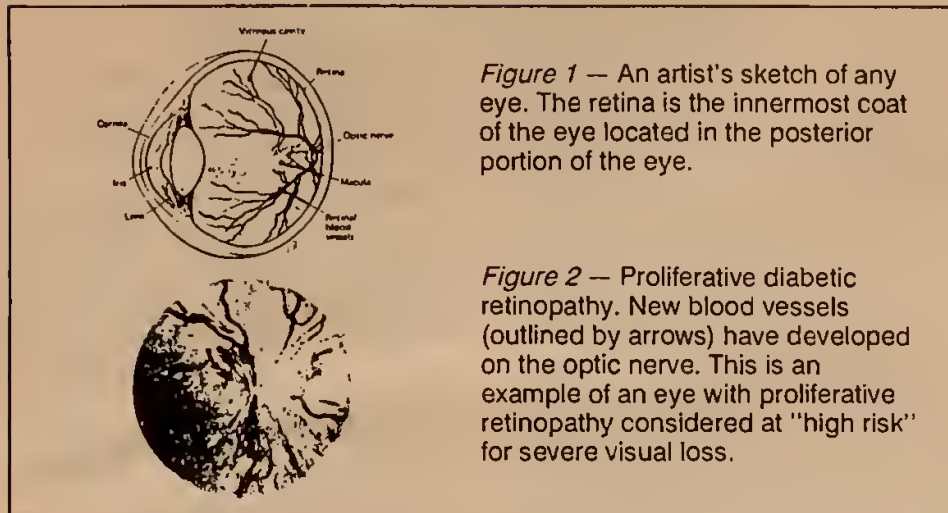


Figure 1 — An artist's sketch of any eye. The retina is the innermost coat of the eye located in the posterior portion of the eye.

Figure 2 — Proliferative diabetic retinopathy. New blood vessels (outlined by arrows) have developed on the optic nerve. This is an example of an eye with proliferative retinopathy considered at "high risk" for severe visual loss.

Insulin 'guinea pig' (Continued from page 10)

discovered earlier that year; no one knew anything about it.

"Of course, now we know it's wonderful stuff. It's kept me alive all these years."

A spokeswoman at Eli Lilly and Co. in Indianapolis confirmed Ubben's 1922 diagnosis and his testing of insulin after its discovery in Toronto. The pharmaceutical company isn't sure if one other member of the first test group is alive. Ubben may be the oldest surviving diabetic, said Gene McCormick, retired Lilly historian.

Ubben suffered frequent bouts with diabetes-related illnesses brought on by ignoring doctors' orders to maintain a strict diet. He became partially blind from an attack in 1938.

He and his wife of nearly 53 years, Wilma, raised three children and worked a small farm. He later ran a coin-operated machine business and worked as a furniture maker and wood sculptor.

Ubben learned the dangers of insulin overdose when he experienced one of the first documented insulin reactions. After his treatment in Indianapolis, he was in a Peoria hospital for observation when he passed out.

"The doctor didn't have any idea what was wrong," said Ubben, who described the episode in an autobiography 10 years ago.

Because the hospital had no facilities to analyze Ubben's blood for sugar content, a specimen was raced to a doctor's laboratory by police.

The lab technician was at the movies. While Ubben's parents were summoned to their "dying" son's bedside, every theater in Peoria flashed an emergency message on

the screen to locate the technician.

The message worked.

The technician raced back to her lab to study Ubben's blood and found the lowest blood sugar she had ever seen.

But the hospital had no glucose to counter the insulin overpowering Ubben's body.

So his doctor pried the unconscious body's teeth apart, shoved a rubber hose down his throat and poured a bottle of corn syrup into his stomach in a crude effort to raise his blood sugar. Ubben was revived.

(Note: This article appeared in the *Democrat*, Sedalia, Mo.)

What color is the sun?

(Continued from page 4)

orange, and it's pretty. I've never seen that before."

I was aware that if I had believed all of the stereotypes about blindness, that I would never have done such a normal thing as to get married and have a child — one I was now sharing a sunset with — because I might have believed that a blind person couldn't take care of a child independently. I was thankful for this Federation-influenced blessing. I was also aware at that moment that this sunset might have gone unnoticed by both of us had we not had our previous discussion. Certainly it would not have been a life-or-death disaster to have missed the sunset, but there was a particular joy in our sharing "What color is the sun?"

The Diagnosis: diabetes; the patient: your very young child

Surviving a family challenge (Continued from page 11)

maintain a healthy diet. I become impatient with those parents, and there are a few, who say, 'This is so hard on the other children, why should everyone suffer because one person has diabetes, when it's the parents who are obviously the ones having a hard time. To them I say, 'Nobody needs an Oreo.' This is one concrete way family members can support the child with diabetes."

"I don't eat anything she doesn't have," says Helen Kraus, of her daughter Rachel, who is now six. "But I find myself constantly being assaulted with situations in which I find that what Rachel eats or doesn't eat is an issue. Most of the time, I can plan in advance but sometimes, if I'm caught by surprise, the results can be very upsetting. Last winter we went to see the Nutcracker, a holiday tradition. During intermission, a woman who meant, I'm sure, to be kind, gave Rachel some candy, which she couldn't have. Rachel couldn't stop crying and on the subway home she said, 'Mama, how come I have diabetes?' "

Injections and Blood Tests. Other tangible stressors for families include issues related to giving insulin shots or testing blood. "Causing pain to your child by giving injections or testing blood as often as four times a day is difficult for most parents," says Anderson.

"Often parents' first response is 'There's no way I can do this' but the truth is they really don't have any choice. When a child has diabetes, the parents are the prime deliverers of treatment."

Though the process can be extremely wearing, Anderson suggests some options that may make it a little easier on both parents and kids. "The best approach is a combination of organization and distraction," she says. "For example, if Mr. Rogers is a favorite TV program, give an injection at the beginning of Mr. Rogers. The anticipation of watching the show will often distract the child from anxiety and discomfort caused by the injection." "Also, whenever possible try to have both parents involved in the injections and testing, which helps with distracting the child but also lessens the burden of one parent being responsible for causing the pain every time."

"One family that has achieved particular success at making injections an acceptable family routine now has to pretend to give their younger daughter who does not have diabetes an injection as well so that she won't feel left out," says Anderson.

Getting support. Once the physical aspects of diabetes have begun to be absorbed into the family routine there is still a broad range of emo-

tional issues that may need to be dealt with. The child may feel that he or she is the only person in the world with diabetes, the parents may be feeling isolated and overwhelmed and wondering where they can look for support, and siblings may be feeling left out or resentful or even jealous of the attention their brother or sister with diabetes is receiving.

For many in the Boston area, support groups such as those run by the Joslin Pediatric Team are the starting point for dealing with these issues.

"We have no extended family in this area," says Kay Tustison. "And in many ways Joslin has become our support system. It wasn't until I participated in one of Barbara Anderson's groups that I met other parents who were also dealing with the same issues we were and my daughter saw that she was not 'the only one' with diabetes."

Similarly, says Helen Kraus, it was at Joslin that her daughter met another child with diabetes for the first time. "We came home," says Kraus, "and Rachel was ecstatic. Her whole demeanor had changed. 'Mama,' she said, 'I've got a best friend.' "

Spurred on by her positive experience in a Joslin-run support group, Tustison formed Parents and Children Together (PACT) last year. The group meets every six weeks in suburban Boston and now has about 28 families and about 35 children, ranging from 15 months to 14 years of age, participating. Meeting expenses are covered by the Massachusetts Chapter of the American Diabetes Association.

PACT enables parents to talk to other parents, while children with diabetes and their siblings all have the opportunity to interact. "Once we grasp the notion that a chronic illness such as diabetes affects the entire family then it becomes less difficult to deal with the psychological issues that are as much a part of having diabetes as the physical effects themselves," says Tustison. "These groups have helped us maintain a positive attitude and continue to feel supported in our management of family life with diabetes."

Too often, says Barbara Anderson, "people underestimate and de-emphasize how hard it is to be a child with diabetes and to be the parents or the sibling of a child with diabetes. This is a great mistake. The result very often is that in striving to be 'normal,' families overlook how much support, strength and stamina is required to cope with diabetes in a young child."

(Note: This press release was received from Joslin Diabetes Center, Boston, Massachusetts.)

Letters to the editor



Peggy Pinder serves as Second Vice-President for the National Federation of the Blind.

Grinnell, Iowa
November 14, 1990

Ed Bryant, Editor
VOICE OF THE DIABETIC

Dear Ed,

In a recent copy of *Volce of the Diabetic*, you requested letters showing how the magazine is useful to its readers. Here is my reply.

As a national officer of the largest organization made up of blind persons in this country, I meet blind people all the time. Blind people call me. I meet them at meetings of the blind. I encounter them in bus stations and airports. They are always interested in what a fellow blind person uses as techniques for those tasks which the sighted do with sight. This is particularly true for diabetics who are very often frustrated by the advice they are getting from family members and from medical professionals. The advice is: Sit back and let someone else manage your diabetes and administer your insulin and handle your dietary calculations and all the complications; blindness makes it impossible for you to do these things.

Not being a diabetic myself, I used to find these frustrations difficult to deal with. I knew that blind diabetic friends of mine managed their diabetes themselves, but I did not know the details. I now do. By reading the *Volce*, I can now explain in detail how management is accomplished and can also get the blind diabetic to a continuing source of information and support.

We in the Federation have found that, when blind people take responsibility for their own lives, major changes occur within them and in the world around them. The key is responsibility. I view my work as an effort to shift responsibility back or keep responsibility upon the blind person for his or her life decisions. When blindness occurs, it is common for the blind person and those

around him or her to conclude that the life decisions cannot be handled by the blind. I can now help the blind diabetic work through this by giving information and a referral for more information. Please make sure that the *Volce* keeps coming. Thanks.

Sincerely yours,
— Peggy Pinder

Sikeston, Missouri
November 6, 1990

Ed Bryant, Editor
VOICE OF THE DIABETIC

Dear Mr. Bryant:

I am writing you not only as a professional in the field of rehabilitation of the blind, but also as a blind diabetic. I have been receiving your publication *Volce of the Diabetic* for quite some time now and want to express to you and the National Federation of the Blind how much I appreciate this informative and practical publication. It has to be one of the most informative and interesting in the field of diabetes or blindness.

As a professional in the field of blindness I have shared this publication with many of my diabetic clients, who are amazed at the content of the magazine. I have learned many techniques to use with my clients in drawing and administering their own insulin and cyclosporine (for those diabetics with transplanted organs), learning how to do their own glucose monitoring and basically just learning how to live more independently as a blind diabetic.

The Diabetics Division of the NFB really has a valuable resource for all diabetics in its publication. The magazine is truly what it says it is, "a support and information network for blind diabetics!" It is great for diabetics to realize that they are not alone in their fight for "normal productive lives." The *Volce of the Diabetic* has given many the support and encouragement to continue to live with a disease that does not have to mean inactivity, helplessness, or inadequacy. It is positive and upbeat, yet realistic.

I want to thank you for your fantastic publication and for your belief in people! You probably don't know just how many blind diabetics' lives you have touched or how many you have helped with physical and emotional difficulties. My guess is that it is far more than we estimate. I urge you to continue to produce such a fine magazine. Your cause is a great one. Thank you again.

Sincerely,
— Eric D. Knoeppel
Rehabilitation Teacher
Missouri Bureau for the Blind

On keeping a promise (Continued from page 10)

that door and down the hall to the nurses' station. Do you need some help?" the receptionist added happily, knowing that she had completed her task.

"No, thank you. We know our way all too well," Charlie replied as he took Coco's lead and they headed towards the door.

"Hello Charlie! How nice to see you," the friendly nurse said as he came through the door. "This is Sally. Do you remember me?" she asked.

"Of course I remember you Sally! That's SALLY all in capital letters."

"Congratulations!" she said as she took Charlie's arm, walking with him and Coco down the hallway. "I saw the news release on T.V. You must feel honored to have had the first pancreas transplant in the Northwest."

"I don't know that I feel so honored, but I sure am glad it was successful," he said with a thoughtful wrinkle to his eyebrow. "It's you, Lady Mary Ann, and all the nurses on 5C who should feel honored," Charlie said as his grin returned. "You are the unsung heroes that kept me going."

"Thanks, Charlie. You're here at the nurses' station now," Sally said. "You take care, and I'll see you later."

"If you will give me those papers and take a seat in the waiting area, the doctor will see you soon," another nurse said as she took the papers from his hand.

"Thanks," he replied as he and Coco walked down the hallway towards the waiting area.

"Look, Mom! That man over there has a dog!" a small boy exclaimed as Charlie was sitting down and Coco lay down by his feet.

"How come that man can bring a dog in here?" the boy questioned his mother.

"Shhh!" his mother groaned in a low voice. "He is blind and that dog guides him."

"Can I go over and pet his dog?" the boy asked with excitement.

"You'll have to ask the man about that," his mother said.

"Hey mister, would it be all right for me to pet your dog?" the boy asked as he approached Charlie.

"Well, he's not working now, so I guess it would be all right," he replied.

"How did you go blind?" the boy said suddenly while he was petting Coco.

"I used to have diabetes," Charlie said calmly.

"That's why I'm here; they say I have diabetes," the boy said with concern.

"I know. I was about your age when I got diabetes," Charlie said with an understanding tone.

"Come on, Timmy," his mother said as she took him by the hand. "The doctor is waiting to see us

now."

Suddenly Timmy turned back saying, "Hey mister! This doesn't mean that I'm going to go blind too, does it?"

"I think it's going to be all right," Charlie said to the boy. "Everything is being done that is possible to cure diabetes, and that I can promise you," Charlie said as he turned his head in the direction of the young boy and smiled towards the future.

Walk this way to better health

The amount of physical exercise in the average American lifestyle has decreased dramatically in the last few decades. Many people take their cars or the bus to work each day, use elevators rather than stairs and sit and watch the television at home rather than be up and about.

One of the most encouraging trends of recent years, however, is the growing interest in and awareness of the need for physical exercise.

Brisk and sustained (aerobic) exercise can help to improve the efficiency of the heart and help people lose pounds of excess body fat and burn calories. To do this, exercise must be **brisk and sustained for at least 15 to 30 minutes** without interruption. It must also be regular.

Walking is probably one of the easiest ways to begin an exercise program. All you need is a safe place to walk and good, comfortable shoes.

Tips on Starting a Walking Program

- Plan to walk at the same time each day to help establish a routine. The best times are before breakfast or before dinner.
- Walk every day rather than every other day. This will help reinforce your exercise routine.
- Walk with a friend or listen to your favorite music, or recorded book, as you walk along.
- To determine the distance of your favorite route, drive the route in your car and check the odometer.

Check with your doctor before making any significant changes in your level of physical activity.

Remember to pay particular attention to the condition of your feet and increase the distance you walk gradually.

Happy Walking!

(Note: This article appeared Fall, 1990 in the *Florida*, published by the Florida Affiliate, Inc. of the American Diabetes Association.)



Recipe corner

Ann Terry is a registered dietitian who works at the State Hospital in Fulton, Missouri and at the Veterans Administration Hospital of Columbia, Missouri. She graciously calculates the diabetic exchanges and food values for our recipes.

Send your great ideas to the editor. He is the official taste tester and needs recipes to test his taster.

Happiness Cake Anonymous

2 heaping cups of patience
1 handful of love
2 handfuls of generosity
1 handful of understanding
A dash of laughter
Generous sprinkle of kindness
Plenty of faith

Combine patience, love and generosity with understanding. Add a dash of laughter. Sprinkle generously with kindness. Add plenty of faith. Mix well.

Spread over a period of lifetime. Serve to everyone you meet. Sit back, relax and enjoy a slice or two every day of the year. Good for all gatherings.

Yummy Snack

Submitted by Karen Mayry
from Rapid City, SD

1 8-oz. container of plain, low-fat yogurt

1 small banana

1 tsp. vanilla or more to taste

2 pkgs. Equal or other sweetener

Cut banana into chunks before adding to other ingredients in blender. Blend until banana is totally smooth.

Two or three spoonfuls will satisfy any sweet tooth.

Yield: 4 - 10 oz. serv.; Calories: 60/serv.; Diabetic Exchanges: 1/2 of 2% milk.

Lamb and Artichoke Stew

Submitted by Annette Anderson
from Cleveland, OH

This recipe appeared in the October-November 1990 issue of the *Braille Monitor*, published by the NFB.

2 lbs. lamb stewing meat, cut in bite-size pieces & trimmed of fat

3 tbs. butter or margarine
3 cups onions, chopped
2 cloves garlic, minced (optional)
1/2 cup fresh parsley, chopped
1 6-oz. can tomato paste
1 cup dry white wine
3 tbs. fresh lemon juice
2 15-oz. cans artichoke hearts, drained
1/2 tsp. dill weed
salt and pepper to taste

In a heavy skillet, brown lamb in butter and remove. Saute the onions, garlic, and parsley. Then return the lamb to the pan.

Add the tomato paste and white wine.

Cover and simmer for one hour or until meat is tender. Add remaining ingredients and simmer for 45 minutes.

Serve over rice.

Yield: 6 servings; Calories: 300/serv.; Diabetic Exchanges: 3 meats, 3 vegetables.

Diabetic Jam

Submitted by Beverly Helmboldt
from Marquette, MI

4 medium apples, peeled and diced (or unpeeled in food processor)

1 tbs. lemon juice

3 packets Sweet and Low

12 oz. unsweetened apple juice

4 cups blueberries (or other fruit)

1/4 cup minute tapioca

1/2 tsp. cinnamon

2 tbs. gelatin

1/4 cup water

12 packets Equal

Cook apples until tender. Add lemon juice and Sweet and Low, and cover with apple juice. Add blueberries (or other fruit), tapioca, and cinnamon. Cook to pudding consistency.

Add additional apple juice if mixture becomes too thick.

In a separate container, stir gelatin, water, and Equal well and set aside until thick.

Add gelatin mixture to fruit mixture. Pour into 8-oz. jars and keep in refrigerator.

Yield: approx. 6 cups (8 oz. jars); Calories: 1 Tbsp. approx. 12 calories; 1/3 cup approx. 60 calories; Diabetic Exchanges: 1 Tbsp. (12 cal.) are free, 1/3 cup (60 cal.) = 1 fruit.

It's on the label

by Claire Hammer, R.D.

(Note: Claire Hammer, R.D. has produced a Diabetes Education videotape and authored several handouts concerning diabetes and nutrition. Following is one of her handouts reprinted with permission.)

There are basically two parts to nutrition labeling:

1.) The list of ingredients.

2.) The nutrition information panel. In the video, a list of ingredients for graham crackers was shown to you. Here is that list again:

Enriched wheat flour, SUGAR, graham flour, partially hydrogenated vegetable oil shortening, BROWN SUGAR, CORN SYRUP, HONEY, sodium bicarbonate, salt, MOLASSES, lecithin, malted cereal syrup and vanilla.

The words in capital letters are all sources of sugar. Once you start reading lists of ingredients you will be surprised at how many foods contain sugar in some form and how few foods do not contain any!

As was stated in the video, you already know that 3 graham cracker squares are one starch exchange. As long as you can find a food on the exchange lists or any other information you may have, it may be eaten. But it is still a good idea to become familiar with lists of ingredients and know what is in your food.

Other ingredients to become familiar with are the "ose" words. Words ending in "ose" such as sucrose, fructose, dextrose, maltose, glucose are all forms of sugar. Other ingredients you may see on a label that indicate sugar are cane sugar, high-fructose corn syrup, invert sugar, raw sugar and cane sweetener.

Remember, it is almost impossible to avoid foods containing some form of sugar and if you know how to plan it in your meals using the food exchange lists you may do so.

One more thing about the list of ingredients. Ingredients are listed in order by their weight. For example, on the graham cracker label the enriched wheat flour is in the greatest quantity, sugar is second and vanilla will be in the least amount.

The nutrition information panel is a little harder to understand. Some of the information you may not even be interested in. The first thing to look at is the serving size. Is it a serving size that is given for that food on the exchange lists? It could be different since the manufacturer of that product is not required to have "exchange list" servings. If you look at the label on the other side of the handout, notice that the serving size for this brand of graham crackers is 4 squares. The serving size on the exchange lists is 3 squares. If you are following an exchange list meal plan always follow those amounts.

Many people are interested in calories. Calorie counting is usually not stressed in meal plans using the Exchange List system. But you have already noticed that the calories listed on the label below are 60 calories for 4 graham crackers. You may also have noticed that 3 graham crackers on the Exchange Lists are 72 calories. All of the Exchange Lists are AVERAGES and may quite often not agree with nutrition labeling. But if you are consistent and always follow one system of meal planning, the differences you find on labels and other meal planning information you may have should not make any difference.

The label will also give you grams of protein, carbohydrate and fat for that serving size. Percentages of the USRDA (United States Recommended Daily Allowances) will be given for many of the vitamins and minerals that you would be receiving from that serving.

Some manufacturers are taking the grams of carbohydrate in the serving size and telling you how much of this carbohydrate is complex and how much is simple. Many people with diabetes try to eat more foods that have more complex carbohydrate than simple carbohydrate. (Complex carbohydrates are absorbed more slowly than simple carbohydrates.)

Below is the nutrition information panel from the box of graham crackers. See if you can answer the following questions by looking at this label:



New book: *Walking Alone and Marching Together*

Walking Alone and Marching Together: A History of the Organized Blind Movement in the United States, 1940-1990, by Floyd Matson.

A STORY NEVER TOLD

This book tells a story — as true as it is dramatic — that has never been told before. It is a story of the epochal struggle and ultimate triumph of a singular American social movement, that of the organized blind, which evolved over the space of half a century from a small vanguard of visionary men and women into a nationwide community of fifty thousand members — recognized throughout the world as a major force in the field of blindness and civil rights.

Unlike previous histories of blindness and the blind, which have dealt almost entirely with the work of benefactors and agencies for the blind, this magisterial study by a distinguished cultural historian — Floyd Matson — breaks new ground in focusing upon the actions and aspirations of the organized blind themselves. It follows the progress of the movement from its historical origins in the remote past to the pioneering adventure of its founding in 1940, then through the early years of lonely struggle for the right of the blind to organize (indelibly associated with the name of John F. Kennedy). Then we see the turmoil of "civil war," followed by renewed harmony, and explosive growth in both size and stature — as symbolized by the establishment of the multi-faceted National Center for the Blind.



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Biographies

FOR THE FIRST TIME, *The Struggles of the Blind as an Emerging Minority in the United States - In their words and from their viewpoint...*

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Allen Harris

Chairman, Social Studies Department and
Chairman, Curriculum Council, Edsel Ford
High School, Dearborn, Michigan

"...a fascinating story of the rise of one segment of American society to first-class citizenship based on its own grassroots efforts."

John Halverson

Program Division Director,
Federal Office for Civil Rights, Region VI

"Eye care professionals, researchers, and rehabilitation specialists serving individuals facing vision loss will gain essential insight and perspective..."

Eileen Rivera

Administrative Director,
Wilmer Vision Research and Rehabilitation Center,
Johns Hopkins University

"This book is an important tool for training professionals who work with minority groups or disabled persons. Every educator who has responsibility for designing and implementing programs to bring minority groups or disabled students into the mainstream should know this story, and no teacher of the disabled should enter a classroom without understanding the aspirations of the blind told in this book."

Homer Page, Ph.D.

Professor of Education
Graduate School of Education,
University of Colorado at Boulder

Floyd Matson has lectured and written widely in the fields of minority rights, social thought, and political action. He is the author or editor of eleven books and is the co-author with Jacobus tenBroek of *Hope Deferred: Public Welfare and the Blind* (1959). He also collaborated with tenBroek on the award-winning *Prejudice, War and the Constitution* (1954), detailing the constitutional implications of the evacuation of Japanese Americans from the West Coast during World War II. Professor Matson teaches American Studies at the University of Hawaii.

NOW AVAILABLE

A complete set of eight-track cassette tapes now available of *Walking Alone and Marching Together* by Floyd Matson.

Cost: \$30.00 plus \$3.00 handling.

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☐ Charge to credit card as follows:

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@ \$30.00 each plus \$3.00 each for shipping and handling.

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Walking Alone and Marching Together
@ \$30.00 each set plus \$3.00 handling.

Total: \$ _____

ORDER FORM

Wound care centers

From the editor: In the last Voice issue, Volume 6, Number 1, the article titled "Wound Care Centers offer bold new approach to healing" appeared. This story was about Procuren®, a new drug that supplements traditional wound healing methods. An editor's note stated that a list of Wound Care Centers which use the new drug would appear in this edition of the Voice. Following is information from a flier which provides locations of wound care centers in the United States.

Curative Technologies, Inc. (CTI), is affiliated with Wound Care Centers through exclusive arrangements with select hospitals throughout the United States. Stressing outpatient care, each Center is staffed by hospital physicians, nurses and technicians. CTI provides Center management, Procuren® processing and medical consultation.

Wound Care Centers only treat wounds, and work in conjunction with the program of care prescribed by the patient's personal physician.

Throughout the healing period, the referring physician continues normal patient contact and maintains responsibility for primary patient care. The Center provides regular reports to aid the physician in monitoring the patient's progress toward healing.

Mt. Vernon Hospital, Wound Care Center, 12 North 7th Avenue, 4th Floor, Mt. Vernon, NY 10550; phone: (914) 664-8000 x 3626.

Wound Care Center of Northern New Jersey, St. Mary's Ambulatory Care Hospital, 135 South Center Street, Orange, NJ 07050; phone: (201) 266-3123/24.

The Graduate Hospital, Wound Care Center, Pepper Pavilion, Suite 1005, 18th & Lombard Streets, Philadelphia, PA 19146; phone: (215) 893-7655/56.

William Beaumont Hospital, Wound Care Center, 3023 North Woodward Ave., Suite 230, Royal Oak, MI 48073; phone: (313) 435-4640/41/42/43.

Holmes Regional, Wound Care Center, 1051 S. Hickory Street, Suite H, Melbourne, FL 32901; phone: (407) 676-7259.

Parkway Regional Medical Center, Wound Care Center, 160 NW 170th Street, N. Miami Beach, FL 33169; phone: (305) 654-5069.

Baptist Hospital, Wound Care Center, 1923 Hayes Street, Nashville, TN 37203; phone: (615) 340-4700.

The Toledo Hospital, Wound Care Center, 3000 Regency Court, Suite 200, Toledo, OH 43623; phone: (419) 843-5277.

Fairview Southdale Hospital, Wound Care Center, Southdale Medical Bldg., 6545 France Ave. South, Suite

C-24, Edina, MN 55435; phone: (612) 924-5043/44.

University of Minnesota, Wound Healing Program, Box 120 UMHC, 420 Delaware St., SE, Minneapolis, MN 55455; phone: (612) 625-5919.

Bryan Wound Care Center, 7441 "O" Street, Suite 200, Lincoln, NE 68510; phone: (402) 483-8370.

The Wound Care Center of Kansas City, Bethany Medical Center, 155 South 18th Street, Suite 105, Kansas City, KS 66102; phone: (913) 281-8821.

Sam Houston Memorial Hospital, Wound Care Center, 4300 Hillendahl, Suite 240, Houston, TX 77055; phone: (713) 973-2670.

Wound Care & Hyperbaric Medicine Center of Southwest Texas, Methodist Hospital, 4499 Medical Drive, SL 2, San Antonio, TX 78229; phone: (512) 696-7293.

Poudre Valley Hospital, Wound Care Center, 1024 Lemay Avenue, Fort Collins, CO 80524; phone: (303) 490-4358.

The San Francisco Wound Care Center, Seton Medical Center, 1800 Sullivan Ave., Suite 207, Daly City, CA 94015; phone: (415) 991-6780.

The San Francisco Wound Care Center, California College of Podiatric Medicine, 1835 Ellis Avenue, San Francisco, CA 94115; phone: (415) 292-0450.

St. Joseph Hospital, Wound Care Center, 845 LaVeta, Suite 107, Orange, CA 92668; phone: (714) 744-8520.

J.T. Mather Memorial Hospital, Wound Care Center, Davis Professional Park, 5225 Route 347, Building 12, Suite B, Port Jefferson Station, NY 11776.

Carraway Methodist Medical, Wound Care Center, 1600 26th Street North, Birmingham, AL 35234; phone: (205) 226-5816.

Presbyterian Hospital of Dallas, Wound Care Clinic of North Texas, 8221 Walnut Hill Lane, Suite 700, Dallas, TX 75231; phone: (214) 891-6035.

Daniel Freeman, Wound Care Center, 323 N. Prairie Ave., #434, Inglewood, CA 90301; phone: (213) 419-8250.



What you always wanted to know but didn't know where to ask



(Resource list)

(Inclusion of materials in this publication is for information only and does not imply endorsement by the Diabetics Division of the NFB.)

Equipment

TeleSensory, 455 N. Bernardo Ave., Mountain View, CA 94043; telephone toll-free: 1-800-227-8414, or locally at (415) 960-0920.

This company carries a comprehensive line of computer products for the blind/visually impaired. For example, a reading system that "scans and converts print documents to be read, modified, or saved on an IBM AT, PS/2 Micro Channel or compatible computer." They also "offer a wide range of products that work with Apple computers to provide large print, speech, Braille, or tactile output."

TeleSensory will have an exhibit booth at this year's NFB Conference July 1-6 at the Hyatt Regency in New Orleans, La.

Accu-Chek II Freedom System Meter with Audio Output: Has a finger guide which assists in getting a drop of blood onto the test strip pad. Once a drop of blood is on the pad, the machine says, "Start the timer." The user receives audio cues throughout self-testing. Dimensions: approximately 12" x 12" x 7", weight about 11½ lbs.; includes cassette instructions. Suggested retail price: \$650-\$700. Contact: Boehringer Mannheim Diagnostics, Inc., 9115 Hague Road, Indianapolis, IN 46250; telephone toll-free: 1-800-428-5074.

Maxi Aids is a distributor that offers the Freedom System for \$598.95 plus \$2.50 handling. Telephone toll-free: 1-800-522-6294.

Diasecan-SVM Blood Glucose Meter with Audio Output: Blood can be smeared on the test-strip pad and still produce an accurate clinical reading. The manufacturer offers a \$125 rebate. Suggested retail price is \$635. With rebate (including cassette instructions) it is \$510. A sample cassette is offered free upon request. Contact: Home Diagnostics, Inc., 6 Industrial Way West, Eatontown, NJ 07724; telephone toll-free: 1-800-342-7226; in NJ call: (201) 542-7788.

Sleep Sentry: Worn like a watch to warn diabetics of nighttime insulin reactions. Perspiration triggers alarm. Cost: \$240 plus \$2 handling. Contact: Diabetes Supplies, Inc., 8181 North Stadium Dr., Houston, TX 77054; telephone toll-free: 1-800-622-5587 or in Houston (713) 662-5587.

Sunbeam Nutriscale II with Voice: This food scale gives total content of carbohydrates, fat, protein, calories, sodium, and cholesterol.

Weights 5 lbs. in ounces or grams. Cassette instructions included. Cost: \$699 plus \$9.50 shipping. Order from: Science Products, Box 888, Southeastern, PA 19399; phone: 1-800-888-7400.

Braille/Tape Exchange List

Exchange list for meal planning: This list is now available in Braille (83 Braille-written pages bound in a nice, durable, plastic cover) and on cassette.

This revision, the first in 10 years, is the result of a joint effort of the American Diabetes Association and the American Dietetic Association and reflects today's food values and eating patterns. It continues to restrict fat but emphasizes high carbohydrate and fiber foods. Nutritive values have been increased in such foods as fruits, milk products and carbohydrate/starch exchanges. New additions include a list of free foods, exchange values of combination foods, and a list of foods for occasional use. There is also a glossary of nutritional terms and an index of foods.

Make tax deductible checks payable to: National Federation of the Blind. Cost: Braille \$10.00, and cassette \$2.00. Order from: Karen Mayry, President, Diabetics Division of the NFB, 919 Main St., Suite 15, Box 6, Rapid City, SD 57701; telephone: (605) 348-8418.

Cassette Review by Ed Bryant

How to Survive the Ups and Downs of Diabetes, by Denise J. Bradley, is a cassette recording I recommend. Denise describes her life as an insulin-dependent diabetic. She discusses all aspects of diabetes, explaining what it is and how she keeps it under control. Her story is encouraging and uplifting.

Following is an excerpt from the two-volume set. "The reason my story has meaning for you is that I was able to turn my life and health around. I went from spending an average of \$4,000 a year for medical expenses to my present cost of only \$1,200. What I'm going to do on this tape is tell you how I did it, by welcoming you to the wonderful world of controlled diabetes. What's in it for you: health, independence, and control over your own life."

Cost: \$12.95 plus \$3.00 mailing. Order from: Upbeat Publications, 1104 Arizona, S.E. #15, Albuquerque, NM 87018; phone toll-free: 1-800-873-2363.

Literature

Note: The following two books are
(Continued on page 20)



Food for thought

Voice Tape Speed

The *Voice of the Diabetic* is recorded at 15/16 inches per second (IPS), which is slower than the standard speed of 1 7/8 IPS. The slower speed allows more to be read onto the cassette.

If the *Voice* tape is played in a standard recorder, it will sound as if it is going too fast, or like a chipmunk.

The National Library Service for the Blind and Physically Handicapped provides special players, free of charge, that play cassettes recorded at 15/16 IPS. Any legally blind person (someone who has trouble reading normal size print) can receive one of the tape players by contacting his or her Regional Library for the Blind, or by telephoning the National Library Service, toll-free: 1-800-424-8567.

Dialysis

During this year's National Convention in New Orleans, Louisiana, dialysis will be available.

Individuals requiring dialysis must have a transient-patient packet and a physician's statement filled out prior to treatment. Patients should have their dialysis units contact the desired location in New Orleans for instruction on what must be done. There is a mandatory prepayment of 20 percent (approximately \$30) which must be paid before each dialysis treatment. This is the amount not covered by Medicare.

Following are three dialysis locations which are close to the Hyatt Regency:

1. Greater New Orleans Artificial Kidney Center, 2000 Tulane Avenue, New Orleans, LA 70112; phone: (504) 581-6227. This location is open 6 days a week (Monday-Saturday) and is about 7 minutes from the Hyatt.

2. Tulane University Hospital, 1415 Tulane Avenue, New Orleans, LA 70112; phone (504) 588-5263. This location is open 3 days a week (Monday, Wednesday, and Friday) and is about 8 blocks from the Hyatt.

3. Touro Infirmary, 1401 Foucher Street, New Orleans, LA 70115; phone: (504) 897-8530. This location is open 6 days a week (Monday-Saturday) and is located about one mile from the Hyatt.

Please schedule your dialysis treatments early, as space may be limited. If your dialysis unit cannot confirm a space for you, contact Ed Bryant for assistance at: 811 Cherry St., Suite 309, Columbia, MO 65201; phone: (314) 875-8911.

National Convention

The annual convention of the National Federation of the Blind will be

held this year in New Orleans, Louisiana and attended by approximately 2,500 blind citizens. There will be fellowship and learning with informative program items, exhibits of the latest technology for the blind, and literature in braille, print and on tape covering all aspects of blindness. Also, there will be tours, which are always fun.

This year, due to another convention being at the beautiful Hyatt Regency, our conference dates start one day later than in previous years. Our activities will begin on Monday, July 1, 1991 and end on Saturday, July 6, 1991. The convention hotel is located in the downtown section near the French Quarter and the Superdome. Adjacent to the hotel is a large shopping center with numerous restaurants.

The address is Hyatt Regency Hotel, 580 Boycepydras Plaza, New Orleans, LA 70140; for reservations, call toll-free, 1-800-233-1234 or locally at (504) 561-1234. Nightly room rates are as follows: single \$28.00, double \$35.00, triple \$38.00 and quad \$40.00. In addition, there is currently an 11% sales tax plus a \$2.00 per night occupancy tax. When making reservations be sure to mention that you will be attending the National Federation of the Blind Convention.

This convention will be great. So, start packing and we'll see you there.

Plan Ahead and be Prepared

At this year's Annual Convention of the National Federation of the Blind there will be many in attendance who are insulin dependent diabetics. Each of us should have the foresight to bring extra insulin and syringes so as to avoid taking time out to go in search of a pharmacy. If the state of Louisiana requires a doctor's prescription, the added expense of a physician's visit would be necessary.

We insulin dependent diabetics should always be prepared in case of an insulin reaction. At a national convention the hotels are jammed with people and the restaurants are usually packed.

At every convention there are a few diabetics who undergo hypoglycemic attacks which, of course, can be avoided. THINK AHEAD! Always carry something sweet such as candy or glucose tablets that can be used for insulin reactions. We should be sure to have, in our rooms, snack foods that will help control our diabetic food needs.

We diabetics can travel anywhere and do almost anything we want. One thing we cannot do is go without food. Our bloodstreams should have a balance of insulin and glucose. If

there is not enough glucose (food) then we have an "insulin reaction".

"Plan ahead and be prepared."

....

You've heard that we're having a lot of trouble with the economy. A number of people have found that they are out of work.

For example, recently there was an unemployed cowboy who had been deranged.

Then, there was an unemployed electrician who was delighted.

An unemployed musician who was denoted.

An unemployed model who was deposited.

And an unfortunate unemployed dry-cleaner who felt depressed.

Support Letters

by Ed Bryant

The *Voice of the Diabetic* continues to grow by leaps and bounds, which is great. However, with increased circulation comes increased cost. Production, mailing, and inflation have caused an astronomical growth in publication expenses.

Good funding sources are foundations and corporations, but to receive a grant from these sources requires a couple of things. First, leaders of our NFB Diabetics Division are writing letters and proposals for submission to appropriate locations. Next is where each of you come in. A one-page letter is needed, stating how the Diabetics Division of the National Federation of the Blind (NFB) has helped you.

Have you learned more about diabetes and how to keep it under control? Have we helped you realize that as a blind person, you can independently draw insulin and test blood glucose levels? Have we helped you realize that you can travel unescorted, and be involved in mainstream society? Has our NFB Job Opportunities for the Blind program assisted you? Have you attended one of our seminars, and was it helpful? Have you been made aware that you have options, regardless of complications you may have experienced? Have you received assistance from our free counseling services?

How has our support and information network served you? If our NFB Diabetics Division and/or the *Voice* has helped you or a loved one, please send a letter to: Ed Bryant, 811 Cherry Street, Suite 309, Columbia, MO 65201; phone: (314) 875-8911.

Spread The Word

by Lorri Riddle

(Note: This article appeared in the Winter 1990 issue of the *Gem State*

Milestones, the newsletter of the NFB of Idaho. Lorri Riddle is the NFB Diabetics Division Representative for Idaho and is actively "spreading the word."

I have some exciting news to share with you about a new plan of action we have taken in the Magic Valley area dealing with diabetes.

In August of this year I was contacted by a nurse on the medical staff of Magic Valley Regional Medical Center. She shared my concern on the importance of informing diabetics about their disease. We got together with health professionals from other medical facilities in the Magic Valley.

I am so happy to announce that we have formed our very first Diabetic Support Group. We had approximately 15 people from all age groups and types of diabetics. In our one-hour meeting I bet there were a couple hundred questions asked about diabetes. We now have a monthly meeting scheduled and many topics and speakers lined up to talk about diabetes.

It saddens me to think of how many people don't really know what diabetes is about. I strongly urge other diabetics to take the same action. I am eager to help anyone who wants to start a diabetic support group in their area.

Let us spread vital information across our great state; and don't forget to get subscriptions to the *Voice of the Diabetic*.



Lorri Riddle co-chairs the position of the NFB Diabetics Division State Representative of Idaho.

1991 JOB New Orleans Seminar

Lorraine Rovig, Director of the Job Opportunities for the Blind (JOB) program, reports that JOB will hold its 1991 National Seminar on Sunday, June 30, from 1 to 4 p.m. at the New Orleans Hyatt Regency Hotel. Regis-

tration will be at the door beginning at 12:00. The seminar is free.

JOB is a joint program of the National Federation of the Blind and the U.S. Department of Labor. (Your tax money at work.) Anyone who is legally blind and looking for work in the United States is invited to register to receive JOB's free nationwide job hunter's magazine on cassette as well as other services. Some services are available to agencies and individuals assisting blind job seekers. Some services are available to employers interested in hiring competent blind workers. Call 1-800-638-7518 to register or for more information on JOB.



Lorraine Rovig is Director of Job Opportunities for the Blind, a national job referral program for blind people.

The national JOB seminar is set up with the blind job seeker in mind. If you have some of the following concerns, it is for you.

- Do you ask yourself, "What job can a blind person do?"
 - Do you want to ask questions about the techniques that allow one to be competitive and successful in real jobs?
 - Do you want to meet someone who successfully uses only blind techniques, or do you need advice on combining low vision techniques with blind techniques? Do you need to know how to plan now for the future when you may have less sight and your low vision techniques won't work for you?
 - Do you need tips on dealing with interviewers or employers?
 - Do you want to meet legally blind people who are scientists, secretaries, mechanics, telephone operators, counselors, salesmen, psychologists, English teachers, or in many other occupations?
 - Do you know anyone who is blind and has a good job? Do you wonder how you can find a job for yourself?
 - Do you have questions about voice output and Braille output computers or the Arkenstone reader vs. the Kurzweil personal reader? Do you need ideas for funding the purchase of these or other useful aids?
- The Job Opportunities for the

Blind national seminar is three exciting down-to-earth, practical, idea-laden hours of information for blind people seeking work. Join us. If you can't make it to the convention, call JOB to receive the cassette copy. We'll help you increase your chances of getting the job of your choice.

Hear Ye, Hear Ye, A Raffle

The Diabetics Division of the National Federation of the Blind (NFB) reaches out and provides support and information to many people. This valuable networking costs money, such as the production cost for the *Voice of the Diabetic*, and we must generate funds to help cover these costs.

Our Diabetics Division has elected to hold a raffle which will be coordinated by our capable treasurer, Bill Parker. The grand prize will be \$200 and the winner's name will be drawn at this year's annual convention of the National Federation of the Blind on Friday, July 6, 1991, in New Orleans, Louisiana. In addition to the grand prize, the person who sells the winning ticket will receive \$100.

The cost of each raffle ticket is one dollar, or a book of six may be purchased for five dollars. Tickets may be purchased from state representatives of our Diabetics Division or by contacting raffle ticket chairman, Bill Parker, Lafayette Tower, 4601 Mayflower Rd., Apt. 2D, Norfolk, VA 23508; phone (804) 623-1638 in the evenings. Anyone interested in selling tickets should also contact Bill.

Please make all tax deductible checks payable to the National Federation of the Blind. Money and sold raffle ticket stubs must be mailed to Bill Parker no later than June 17, 1991, or they can be personally delivered to him at this year's convention in New Orleans, Louisiana. This raffle is open to everyone and raffle participants need not be present at the drawing to win.

Display Tables

This year's annual convention of the NFB will take place in New Orleans, Louisiana, Monday, July 1 through Saturday, July 6, 1991. At this momentous event our Diabetics Division has reserved space in the exhibit hall.

There will be hundreds of display tables with products and information that may be of interest to blind persons.

Our Diabetics Division will display literature and equipment that will be of interest to blind diabetics or to anyone interested in diabetes.

CAN YOU HELP? It takes many people to work the display tables, and if you can help for two hours, four hours, or more, please contact our display table chairman: Bill Parker, Lafayette Tower, 4601 Mayflower Rd., Apt. 2D, Norfolk, VA 23508; phone: (804) 623-1638.

Elections Coming Up

At this year's National Convention in New Orleans, Louisiana, elections will be held to fill divisional board po-

sitions. These are one-year terms that will run from July 1, 1991 to June 30, 1992. Positions to be filled are: President, First Vice-President, Second Vice-President, Secretary, and Treasurer. If you are interested in a board position, or know someone who you think would do a good job, then contact our Diabetics Division President, Karen Mayry. Yes, hard work and dedication are prerequisites of each board position. Anything worthwhile is usually challenging and requires hard work. Leadership should be a positive force, and one should lead by good example.

For Sale

We have been asked to print the following:

One Perkins Braille writer with carrying case for sale. This Braille writer is almost like new and is in good condition. At \$300, it is a bargain, but willing to negotiate.

Please contact Mrs. Calusine, 8 Burnwood Drive, Bloomfield, CT 06002; phone (203) 242-3638.

Bimonthly Classifieds

We have been asked to carry the following announcement:

"*Bimonthly Classifieds for the Visually Impaired*" is an audio cassette designed specifically to meet the advertising and shopping needs of the visually impaired. However, anyone, blind or sighted, can subscribe or place an ad.

Advertise a single item you would like to buy, sell or trade for just \$1; ads of a personal nature are also \$1. Advertise crafts, services or products for \$2 each. Advertise the availability of your company's catalog for \$3.

With an annual subscription fee of only \$12, you should take advantage of this unique offer. Everyone is entitled to place a free ad within one year of subscribing.

After joining, you will receive a free gift each time a new subscriber lets us know they heard about "*Bimonthly Classifieds*" from you. There's no limit!

Subscribers are automatically entered in the Christmas cash drawing to be held each December 8th: first prize \$100, second prize \$50, and third prize \$25.

To subscribe, make check or money order for \$12 payable to Chilton and Company and mail to 4905 Park Avenue, Nashville, Tennessee 37209. Be sure to include your name, address and telephone number. A sample copy of "*Bimonthly Classifieds for the Visually Impaired*" may be obtained for \$1.00.

Ads and subscription information may be submitted in Braille, print or on cassette. If you have any questions, please contact Chilton and Company at (615) 385-9974.

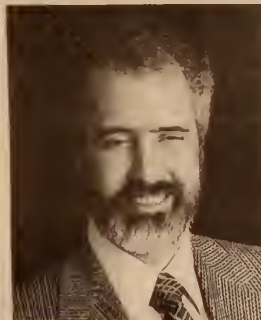
Volunteer of the Week

(Note: The following was adapted from an article that appeared in the *Columbia Daily Tribune*, June 11, 1990, Columbia, Missouri.)

Ed Bryant was living in St. Louis when he lost his sight 13 years ago

because of complications from diabetes.

The son of Wilbur and Gertrude Bryant then returned to Columbia where he had grown up. Since that time, the 45-year-old former photographer has lived with his wife, Gail, who is also blind, and dedicated himself to volunteering and working for the National Federation of the Blind.



Ed Bryant, Editor, *Voice of the Diabetic*, says that "education about blindness and diabetes is essential."

Often putting in 50 or 60 hours a week, Bryant, who has also had a kidney transplant, directs his energy toward educating the public regarding blindness, especially newly blinded people and those with diabetes. He is especially proud of his involvement in establishing the Federation's Diabetics Division and initiating its magazine, the *Voice of the Diabetic*. The first issue of the *Voice* had about 600 copies. Today, just five years later, the quarterly circulation is 35,000-plus. Ed and his driver spend several days delivering it to hospitals and businesses.

Tom Stephens, field representative for the National Federation of the Blind, attributes the publication's success to its commitment to motivate and assist people with diabetes.

As well as being in print, the *Voice of the Diabetic* is also offered on cassette tape.

"I think the NFB Diabetics Division and our magazine provide support for literally thousands of diabetics," says Bryant. "I get the satisfaction of helping people, especially those who are losing vision due to diabetes. Often people don't realize they can be active when blind and can be involved in the mainstream of society. I try to set an example for them."

In addition to publishing the *Voice*, that "example" involves counseling people with diabetes, presenting workshops and speaking anywhere he can to help people better understand blindness. Bryant travels alone by air and bus, often paying costs out of his own pocket.

After losing his own sight, Ed Bryant sees more clearly than ever what he wants to do — help others.

(Continued on page 20)

Articles Needed

If you are a health professional, a person with diabetes, or the family member of a diabetic, we invite you to submit an article for publication in the *Voice of the Diabetic*.

If you have diabetes, have you experienced a diabetic complication? If so, your story can be inspiring for thousands of men and women who are facing the same side effect(s).

One of the goals of the Diabetes Division of the NFB is to show people that they have options regardless of diabetic complications. Are you blind or losing vision? Have you had a kidney transplant? Do you have nerve damage? Have you had an amputation? None of these problems has to be overwhelming. It is helpful to know that others have been down the same road.

All submissions to the *Voice* must be upbeat, because our philosophy regarding diabetes is positive. For information and article submission guidelines, contact: Ed Bryant, Editor, *Voice of the Diabetic*, 811 Cherry St., Suite 309, Columbia, MO 65201; telephone (314) 875-8911.

What's Coming Up

In the next *Voice* edition, Volume 6, Number 3, there will be an evaluation of systems for non-sighted measurement of insulin. Another article will discuss questions from blind diabetics. The topics will be "determining level of insulin in the vial" and "making injections as a blind diabetic." As always, other articles covering different aspects of diabetes will be presented.

ADVERTISERS

Effective advertising doesn't scream at its audience. It persuades. It sells. The key to cost-effective advertising is making your voice heard where an audience is already listening. *Voice of the Diabetic* offers such an outlet. Make your voice heard. For advertising information contact:

Voice of the Diabetic
Ed Bryant, Editor
811 Cherry Street, Suite 309
Columbia, MO 65201
(314) 875-8911

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Complete Starter Kit (weighs 1.8 lbs.) Includes Meter, Voice Module, 50 Test Strips, DCLC Carrying Device, Lincob, Control Solution, and Pen. Carry Case.

DIASCAN is a trademark of Home Diagnostics, Inc.

- DIASCAN Test Strips allow "smearing" of blood sample without significantly affecting clinical result of test¹
- DIASCAN-SVM is a simple, easy-to-use system that speaks your language
- Complete Starter Kit now available

¹F. Folkowski: "Effect of Technique Variations on Test Results of a Blood Glucose Monitoring System" AADE Meeting Presentations: August 1988



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For product information, sample cassette tape, and nearest distributor please call 1-800-DIASCAN; in NJ 1-201-542-7788

Subscription/Membership

FREE

FREE

One-year introductory free offer! The *Voice of the Diabetic* is a quarterly magazine published by the National Federation of the Blind (NFB) Diabetics Division for anyone interested in diabetes, especially diabetics who are blind or losing vision. It is an outreach publication emphasizing good diabetic control, diet, and independence. This one-year free offer is good now through Monday, July 15, 1991. This offer is only for new members and subscribers. It does not apply to renewals.

You may receive the *Voice* absolutely free for one year. Please check one of the following:

- ☐ I would like to receive the *Voice* for one year at no charge as a member of the NFB Diabetics Division. To renew at year's end, the cost will be \$5.00 per year. (Members of our Division enjoy certain advantages, such as that should a side effect occur, they can be put in touch with others having a similar experience.)
- ☐ I would like to receive the *Voice* for one year at no charge as a non-member or institution. To renew at year's end, the cost will be \$15.00 per year.

Send the *Voice* in (check one): ☐ print ☐ tape (for the blind, recorded at 15/16 IPS) ☐ both

Please fill out the following form (print clearly):

Name _____

Address _____

City _____ State _____ Zip _____

Telephone Number (_____) _____

Send this form or a facsimile to the editor by July 15, 1991:
Ed Bryant, 811 Cherry St., Suite 309, Columbia, MO 65201

What you always wanted to know

(Continued from page 17)

sold by Diabetes Center, Inc., DCI Publishing, P.O. Box #739-815, Wayzata, Michigan 55391; phone: (612) 541-0239 ext. 815; phone toll-free non-metro Minnesota: 1-800-444-5951 ext. 815; phone toll-free outside Minnesota: 1-800-848-2793 ext. 815.

The Joy of Snacks by Nancy Cooper, R.D. "There are over 200 recipes in 12 categories including hearty snacks, popcorn, appetizers, muffins/breads, and a special chapter on children's recipes. Each recipe includes nutritional information as well as exchange values per serving. Similar nutritional information is listed for commercial snacks, including exchange values." 269 pages. Cost \$12.95.

Exchanges for All Occasions by Marion J. Franz, M.S., R.D. "Included are meal planning suggestions for traveling, entertaining, camping, eating ethnic foods, school lunches, exercising, following a vegetarian diet, parties and much more." There are special instructions for people with diabetes, and sample meal plans are included. 249 pages. Cost \$8.95.